Medicaid Managed Care

Risk Contract

Between

The State of North Carolina

Division of Medical Assistance

And

WELLPATH SELECT, INC.

Effective August 13, 2003

Division of Medical Assistance
Managed Care Section
1985 Umstead Drive
Raleigh, NC 27603

Table of Contents

APPENDICES

2003

CONTRACT FOR SERVICES

BETWEEN

THE STATE OF NORTH CAROLINA

DIVISION OF MEDICAL ASSISTANCE

AND

_____

A HEALTH MAINTENANCE ORGANIZATION

This Contract is entered into this 1st day of _____ between the State of North Carolina, Division of Medical Assistance, with a principal place of business located at 1985 Umstead Drive, in the City of Raleigh, County of Wake, State of North Carolina and _____, a corporation organized and existing pursuant to laws of the State of North Carolina, which is licensed as a health maintenance organization (HMO), with a principal place of business located at _____ in the city of _____, County of _____, State of North Carolina.

WHEREAS, the Division of Medical Assistance of the State of North Carolina (the "Division") is charged with the administration of the North Carolina State Plan for Medical Assistance (the "State Plan") in accordance with the requirements of Title XIX of the Social Security Act, as amended, (the "Act") and Articles 67 and 68 of Chapter 58 of the North Carolina General Statutes and;

WHEREAS, _____ (the "Plan") is an entity eligible to enter into a risk contract in accordance with Section 1903(m) of the Act and 42 C.F.R., Parts 434 and 438 and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 C.F.R. Parts 434 and 438 and is licensed as a health maintenance organization ("HMO") by the North Carolina Department of Insurance, pursuant to Articles 67 and 68 of Chapter 58 of the North Carolina General Statutes; and,

WHEREAS, the Division desires to contract with health maintenance organizations to obtain services for the benefit of certain Medicaid Recipients residing in the county of Mecklenburg; and,

WHEREAS, the Plan has provided to the Division continuing proof of its capability to provide quality services efficiently, effectively, and economically during the term of this Contract, and continuing proof of its financial responsibility, including adequate protection against the risk of insolvency, upon which the Division relies in entering into this contract;

NOW THEREFORE, the parties hereby agree as follows:

SECTION 1 - GENERAL PROVISIONS

1.1 Definitions and Construction

The terms used in this Contract shall have the definitions set forth in Appendix I**,** unless this Contract expressly provides otherwise. References to numbered Sections refer to the designated Sections contained in this Contract. Titles of Sections used herein are for reference only and shall not be deemed to be a part of this Contract. Appendices I-XVIII are attached hereto and incorporated herein by reference. In the event of a conflict between this Contract and the documents incorporated into this Contract by reference, the terms of the Contract shall govern.

1.2 Governing Law

In connection with the performance of its obligations under this Contract, the Plan shall comply with all applicable Federal and State regulations and laws (statutory and case law), including Rules of the Division and of the North Carolina Department of Insurance, Division policy and all Federal Medicaid Act provisions which have not been expressly waived by the Centers for Medicare and Medicaid Services (CMS). The Plan must meet Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines as required by Federal law and regulation.

Any provision of this Contract which is in conflict with Federal Medicaid statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations and Federal policy. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Except as set forth above, the validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties to this contact, as governed by the laws of North Carolina. The place of this contract, and all transactions, agreements relating to it, and their situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to its validity, construction, interpretation, and enforcement, shall be determined.

1.3 Non-Discrimination and Equal Employment Opportunity

The Plan shall comply with all Federal and State laws which prohibit discrimination on the grounds of race, color, age, creed, sex, religion, national origin, or physical or mental handicap, including Title VI of the Civil Rights Act 42 U.S.C. 2000d and regulations issued pursuant thereto; the Americans with Disabilities Act, 42 U.S.C. 12101 et seq., and regulations issued pursuant thereto; Title IX of the Education Amendments of 1972 and regulations issued pursuant thereto; the Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et. seq., and regulations issued pursuant thereto; the Rehabilitation Act of 1974, as amended, 29 U.S.C. 794, and regulations issued pursuant thereto; and Executive Order 11246 "Equal Employment Opportunity" as amended by Executive Order 11375 and the Byrd Anti-Lobbying Amendment, 31 U.S.C. 1352 and regulations issued pursuant thereto and furthermore shall not use any policy or procedures that discriminate on the basis of health status or need for health care services against individuals eligible to enroll.

In the provision of services under this agreement, the Contractor and its subcontractors shall comply with all applicable federal and state statues and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations.

1.4 Conflict of Interest

No public official of the State of North Carolina, including the Division's contracted enrollment broker (Health Benefits Manager), and no official or employee of CMS or any other State or Federal agency which exercises any functions or responsibilities in the review or approval of this Contract or its performance shall voluntarily acquire any personal interest, direct or indirect, in this Contract or any subcontract entered into by the Plan. The Plan hereby certifies that no officer, director, employee or agent of the Plan, any subcontractor or supplier, and no person with an ownership or control interest in the Plan, any subcontractor or supplier, is also employed by the State of North Carolina or any of its agencies, the Fiscal Agent or any other agents of the Division, CMS or any agents of CMS.

1.5 Reinsurance

The Plan may obtain reinsurance at its own cost for coverage of Members under this Contract, provided that the Plan remains substantially at risk for providing services under this Contract.

1.6 Force Majeure

Neither party to this Contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party. Such acts include natural disasters, strikes, riots, and acts of war and similar occurrences.

1.7 Disputes

If a dispute arises under this Contract, which cannot be disposed of by agreement between the Division and the Plan, the Plan shall request a reconsideration review before the Division. Such request shall be made in writing no later than thirty (30) days from the date of the initial written determination letter from the Assistant Director for Managed Care and Regulatory Affairs. This review is an informal proceeding and shall proceed in accordance with 10 NCAC 26K. Pursuant to 10 NCAC 26K, if the Plan disagrees with the reconsideration review decision it may request a hearing pursuant to N.C.G.S. 150B-23. The Plan shall proceed diligently with the performance of this Contract until the reconsideration review decision is rendered, and in the event the Plan requests a hearing pursuant to N.C.G.S. 150B-23, until the final agency decision is rendered.

The Plan, by signing this contract, agrees and submits, solely for matters concerning this contract, to the exclusive jurisdiction of the courts of North Carolina and agrees, solely for such purpose, that the only venue for any legal proceeding shall be Wake County, North Carolina.

1.8 Disclosure of Information on Ownership and Control

The Plan shall disclose to the Division information on ownership and control of the Plan prior to the beginning of the Contract term, as set forth in Title 42 C.F.R. 455.104.

1.9 Disclosure of Information on Business Transactions

Plans which are not Federally qualified HMOs must disclose to the Division information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act (see Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.). This requirement is detailed further in Appendix XII.

1.10 Conversion Privileges

The Plan shall offer any Member covered under this Contract the opportunity to convert to a non-group enrollment contract consistent with conversion privileges offered to Members of other groups enrolled in the HMO. Any Member who ceases to qualify as a Member under Section 4.8, Involuntary Disenrollment, is not eligible for conversion privileges.

1.11 Contract Officers

The Managed Care Program Director of the Division shall serve as the Contract officer for the Division. The Chief Executive Officer of the Health Plan shall serve as the Contract officer for the Plan. Each Contract officer reserves the right to delegate as may be appropriate, such duties to others in the respective officer's employment.

1.12 Notices

All notices pursuant to this Contract shall be deemed duly given upon the delivery, if delivered by hand (against receipt), or three (3) calendar days after posting, if sent by registered or certified mail, return receipt requested, to a party hereto at the address set forth below or to such other address as a party may designate by notice pursuant hereto.

Plan: WellPath Select, Inc.
6330 Quadrangle Drive, Suite 500
Chapel Hill, NC 27517

Division: Assistant Director, Managed Care and Regulatory Affairs
North Carolina Division of Medical Assistance
2516 Mail Service Center
Raleigh, NC 27699-2516

1.13 Affiliations with Individuals Debarred by Federal Agencies

The Plan may not knowingly have an individual who has been debarred, suspended or otherwise excluded from participating in procurement activities in the following:

- As a director, officer, partner or person with beneficial ownership of more than five percent (5%) of the Plan's equity; or
- Have an employment, consulting or other agreement with such a person for the provision of items and services that are significant to the entity's contractual obligation with the Division.

The Plan must certify to the Division in writing that it meets these requirements prior to participating in the Medicaid program and at any time there is a changed circumstance from the last such certification. The Plan may rely on the participants' certification that they are not currently debarred for purposes of determining that the participants meet these requirements.

The Division shall terminate a contract with any entity that is found to be out of compliance with these provisions. The Division shall not renew or otherwise extend the existing contract with the Plan unless the Division, in consultation with CMS, determines that compelling reasons exist for doing so.

1.14 Beneficiary

Except as herein specifically provided otherwise, this Contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this Contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Division and the named Contractor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Division and Contractor that any such person or entity, other than the Division or the Contractor, receiving services or benefits under this Contract shall be deemed an incidental beneficiary only.

SECTION 2 - CONTRACT PROCUREMENT AND MAINTENANCE

2.1 Procurement Process

Upon release of a Request for Applications (RFA) by the Division, Health Maintenance Organizations licensed by the North Carolina Department of Insurance, pursuant to Articles 67 and 68 of Chapter 58 of the North Carolina General Statutes, may apply to enter into a prepaid capitated risk contract with the Division to provide services to certain Medicaid Recipients. The applicant must submit information in a format prescribed by the Division that fully describes its ability to meet the specifications of the Contract.

All Plans applying to participate must provide detailed information on the provider network available to Medicaid Recipients, including both Primary Care Providers (PCPs) and specialists. The applicants must demonstrate to the Division that sufficient specialty care providers are available to meet the needs of both children and adults with special needs.

Applications must be received by the Division within the time frame specified by the Division and shall be reviewed in the order received. The review of an application shall be suspended if and when it is found to be incomplete and additional information is requested. The review shall not resume until all of the necessary information has been received by the Division.

All applicants who are determined by the Division to fully meet the requirements of the Contract shall be approved for the initial term. Upon approval, the Division and the Health Maintenance Organization shall enter into a written contract. Contracts, which exceed one (1) million dollars, must be prior approved by CMS.

Contracts cannot contain any assertion or statement (whether written or oral) that the Plan is endorsed by CMS, the Federal or State government or similar entity.

2.2 Initial Term

The term of this contract shall begin at 12:01 a.m. on _____ and shall continue for the period of three years, at 12:00 midnight on September 30, 2005, subject but not limited to the provisions in Section 13 – Default and Termination and Section 10.4 – Calculation of Rates.

2.3 Renewal Term

This Contract is a three-year contract and may be renegotiated at the end of the three-year period.

2.4 Extension of Contract

This contract may be extended upon written agreement by both parties in situations where negotiations for the new contract are not complete by the expiration date of the Contract.

2.5 Contract Amendments

The Division may initiate amendments to this Contract when necessary due to changes in State and Federal law, or State, Federal or Division policy and regulations. The Division shall notify the Plan of the need to revise the Contract and shall give the Plan an opportunity to provide input before executing the amendment. The Division shall review the impact of such changes in capitation reimbursement to the Plan.

SECTION 3 - MEMBER ELIGIBILITY

3.1 Persons Eligible for Enrollment

To be eligible to enroll in the Plan established pursuant to this Contract, a person must be a recipient in the North Carolina Medical Assistance (Medicaid) Program in one of the aid categories listed below; and residing in Mecklenburg County; and not eligible for Medicare. The estimated sizes of the eligible aid categories are listed in Appendix II.

a. Individuals covered under Section 1931 of the Social Security Act (1931 Group)
b. Optional Categorically and Medically Needy Families and Children not in Medicaid deductible status (MAF)
c. Blind and Disabled not in Medicaid deductible status (MAB, MAD, MSB)
d. SSI Recipients under age 65
e. Medicaid for Pregnant Women (MPW)
f. Medicaid for Infants and Children (MIC)
g. Adult Care Home Residents (SAD)
h. Foster Care Children (HSF, IAS - Eligible at discretion of Department of Social Services (DSS) and guardian.)

3.2 Persons Ineligible for Enrollment

The following categories of Recipients are not eligible to enroll in the Plan:

a. Medicare Qualified Beneficiaries (MQB)
b. Medicare/Medicaid Dual Eligibles
c. Non-qualified Aliens or Qualified Aliens during the five (5) year ban
d. Medically Needy in deductible status
e. Nursing Facility Residents
f. Medicaid for the Aged (MAA)
g. Residents of Intermediate Care Facilities for the Mentally Retarded
h. Recipients with Presumptive Eligibility
i. Refugee Assistance
j. Participants in Community Alternatives Programs (CAP/DA, CAP/MR-DD, CAP/AIDS, CAP/C)

SECTION 4 - ENROLLMENT AND DISENROLLMENT

4.1 Plan Selection

Recipients shall select and be assigned to a Plan through the Mecklenburg County Department of Social Services (DSS) or an independent Health Benefits Manager (HBM) who shall perform this function under separate contract to the Division. The Plan is prohibited from enrolling Recipients directly or conducting any point of sale marketing. The Plan shall provide for a continuous open enrollment throughout the term of this Contract and shall enroll all eligible Recipients without restriction, in the order in which they apply through the county DSS or HBM; and shall further agree to enroll up to a minimum of 5,000 Recipients, subject to the limitations set forth in Sections 4.2 and 6.8.

The Plan shall not discriminate against individuals eligible to enroll on the basis of race, color, or national origin and shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin. Furthermore, the Plan shall not discriminate on the basis of health status or the need for health care services against individuals eligible to enroll.

Eligible family members in the same case must select the same Plan. Family members shall be permitted to choose different providers within the same Plan. Eligible Members residing in the same household are encouraged to select the same Plan, but are not required to do so. Eligible Recipients who do not voluntarily select a Plan within ten (10) business days of the date of interview with the county DSS or HBM, (thirty days (30) for MAD and MAB Recipients), shall be assigned to a Plan according to an algorithm approved by the Division.

4.2 Change of Household Composition

The Plan shall report to the County DSS any change in the household composition of Members, including changes in family size, marital status or residence, within five (5) days of such information being known to the Plan.

4.3 Newborns

Newborns of Members shall be automatically enrolled and covered by the mother's Plan, effective from the first day of the month of birth. The Plan shall obtain a record of the birth from the hospital in which the birth took place, and shall notify the County DSS of all births to Members within five (5) business days from the date of birth.

4.4 Effective Date of Enrollment/Disenrollment

An enrollment period shall always begin on the first day of a calendar month and shall end on the last day of a calendar month, with the exception of newborns. Disenrollments and plan transfers shall be effective no earlier than the first of the month following the request or reason for disenrollment or transfer, and no later than the first of the second month following a request or reason for disenrollment or transfer.

4.5 Retroactive Disability Determination

When a retroactive disability determination is made for a Recipient who is enrolled in a Plan, the change in payment category shall occur at the time of the change in the Recipient's aid program category within the Division's Eligibility Information System (EIS). Changes in recipient aid program categories are not generally retroactive for the Blind and Disabled.

4.6 Automatic Re-Enrollment

A Recipient whose membership in the Plan is terminated due to ineligibility as defined in Section 3 – MEMBER ELIGIBILITY shall be automatically re-enrolled in the Plan if eligibility is resumed within two months, unless the recipient selects a new Plan.

4.7 Automatic Disenrollment

A Recipient shall be automatically disenrolled from the Plan if the Recipient:

a. no longer resides in the Service Area;
b. is deceased;
c. is admitted to a long-term care facility or a correctional facility for more than thirty (30) days;
d. no longer qualifies for Medicaid or becomes a Recipient ineligible for enrollment as defined in Section 3.2.

4.8 Involuntary Disenrollment

The Plan may request involuntary disenrollment of a Member only for Good Cause, and must submit such request in writing, including remedial steps taken and documentation of good cause, to the Division. Good Cause is defined as:

a. Behavior on the part of a Member, which is disruptive, unruly, abusive, or uncooperative to the extent that the ability of the Plan to provide services to the Member or other affected Members, is seriously impaired;
b. Persistent refusal of a Member to follow a reasonable, prescribed course of treatment; or
c. Fraudulent use of the Medicaid card or the Member ID card issued by the Plan.

If the Plan requests the disenrollment of a Member, the reasons for disenrollment may not be discriminatory in any way against the Member, i.e., adverse change in a Member's health status; non-compliant behavior for individuals with mental health and substance abuse diagnoses; pre-existing medical conditions; high cost medical needs; need for health care services or the exercise by a Member of their right to file a complaint, grievance or appeal. Requests for involuntary disenrollments must be submitted in writing to the Division. The Division shall render a decision within ten (10) business days of receipt of request and adequate supporting documentation. Involuntary disenrollments, which are granted by the Division, are subject to the data processing deadlines as set forth in Section 4.4 – Effective Date of Enrollment/Disenrollment.

The Plan shall submit to the Division its policies and procedures for assuring that each disenrollment request is consistent with Good Cause, as defined in this Section. The written policies and procedures must include a description of the remedial steps the Plan shall take to obtain Member compliance, preceding all requests for involuntary disenrollment.

4.9 Voluntary Disenrollments and PlanTransfers

Members may voluntarily disenroll from the Plan, and transfer to another available health care option at any time without cause. The recipient (or his or her representative) must submit an oral or written request for disenrollment to the Division or the Division's designee. The transfer shall be effective the first day of the next calendar month, subject to data processing deadlines, but in no case shall it be effective later than the first day of the second month after the transfer is requested.

4.10 County Transfers

When Members transfer to another county, they must report the change of residence to the DSS. Section 4.2 of the Contract also requires the Plan to report a Member's change of residence to the DSS. Upon notification of such change, the Member shall be disenrolled from the Plan. The effective date of the disenrollment is subject to data processing deadlines. The Plan is responsible for all medically necessary services to the Member until the disenrollment occurs.

4.11 Group Home and Rest Home Residents

If a Medicaid recipient is enrolled in an HMO and a request is made either by the Plan, a group home or rest home, or a Medicaid recipient or their guardian to exempt the recipient from the managed care program due to relocation to a group home or to a rest home, the Division shall issue an exemption code which shall be effective the first of the month in which the request for exemption is made.

SECTION 5 - MARKETING

5.1 Marketing

The Plan may develop marketing materials in all media such as brochures, fact sheets, posters, billboards, radio and television advertising, to solicit eligible Recipients for enrollment; however, the Plan shall obtain the prior written approval of the Division of all marketing plans and materials that shall be distributed to, or aimed at Medicaid Recipients, including any material or advertising campaign that mentions Medicaid, the Division of Medical Assistance, or Title XIX. All marketing activities must be directed to the entire service area under the Contract. The Plan shall have written procedures for monitoring its enrollment practices. All materials must pass current North Carolina readability requirements, G.S. 58-38-1 et. seq. and G.S. 58-67-65 (a)(3) and must provide an accurate description of the Plan's rules, procedures, benefits, services, and other information necessary for Recipients to make an informed decision. Any advertisement, solicitation material, member handbook, etc. found to be in conflict with the benefits provided shall be interpreted in favor of the Recipient.

Any advertisement, solicitation material, member handbook, etc. found to be in conflict with the benefits provided shall be interpreted in favor of the Division. The Plan must provide materials in English, Spanish and other languages, as may be determined necessary by the Division.

The Plan shall be required to participate in County and Division-sponsored functions for the purpose of providing consumer education and marketing to potential Members.

The Plan is prohibited from:

a. door-to-door, telephonic or other 'cold-call' marketing;
b. engaging in marketing activities that could mislead, confuse, or defraud Medicaid Recipients, or misrepresent the Plan, its marketing representatives, or the Division;
c. offering financial incentives, including other insurance products, to Recipients as an inducement to enroll in the Plan; and
d. making any assertion, written or oral, that the recipient must enrollee in the Plan in order to obtain benefits or in order not to lose benefits.

SECTION 6 - DUTIES AND RESPONSIBILITIES OF THE PLAN

6.1 Performance Standard

The Plan shall perform all duties and responsibilities set forth in this Contract and shall develop, produce and deliver to the Division all of the statements, reports, accountings, claims and documentation described herein, and the Division shall make payments to the Plan in full consideration thereof on a capitated basis as described herein. The Plan agrees that failure to comply with the provisions of this Contract may result in the recoupment of payments, assessment of refundable or non-refundable penalties, suspension of Member enrollment, assessment of liquidated damages or termination of this Contract, in whole or in part. Any payments due hereunder may be withheld until the Division receives from the Plan all written and properly executed documents as required by this Contract.

6.2 Covered Services

The Plan shall provide to Recipients enrolled under this Contract, directly or through arrangements with others, all of the Covered Services identified in Appendix III and as set forth in this contract. Covered services must be medically necessary and provided by, or under the direction of a physician. The Plan shall provide the same standard of care for all Members regardless of eligibility category, and shall make all services as accessible in terms of timeliness, amount, duration and scope, to Medicaid Members, as those services are to non-enrolled Medicaid Recipients within the same area. The Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition. Organ transplants shall be covered under the same conditions as fee-for-service. Covered services are defined in the respective Medicaid Provider Manuals and Bulletins, which are incorporated by reference. The Plan shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate.

6.3 Emergency Medical Services

In accordance with 1932(b)(2) of the Social Security Act as amended by the Balanced Budget Act (BBA) of 1997, the Plan shall provide coverage for emergency services consistent with the prudent layperson standard, as defined in Appendix I. Such services shall be provided at anytime without regard to prior authorization and without regard to the emergency care provider's contractual relationship with the Plan. The Plan shall also comply with guidelines relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to a Medicaid enrollee who is determined to be stable by a medical screening examination, as required under the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act – EMTALA. (Section 1867 of the Social Security Act). (See Appendix XVI). The Plan is responsible for educating Members on the availability, location**,** and appropriate use of emergency services. The Plan may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including but not limited to, cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. 438.114(a) of the definition of emergency medical condition. The Plan shall not deny payment or treatment obtained when a representative of the Plan instructs the enrollee to seek emergency services.

6.4 Accessibility of Services

The Plan must establish and maintain appropriate provider networks that are sufficient to provide adequate access to all services covered under the contract for the enrolled Medicaid population, including children with special health care needs. These provider networks shall offer an appropriate range of services and access to primary care, preventive services, and specialty services. This network of appropriate providers must be supported by written agreements. The network must have a sufficient number, mix, and geographic distribution of providers of services to assure the Division that medically necessary Covered Services for the Plan's Members are delivered in a timely and appropriate manner according to the Division's

Access Standards (Appendix XV). If particular specialty physician services are medically necessary but are not accessible within the Plan's network, the Plan must arrange for these services to be provided to its enrollees. The Plan must adequately and timely cover these services out of network for the enrollee for as long as the Plan is unable to provide them in network. The Plan shall ensure that all Covered In-Plan Services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid Recipients within the area and that no incentive is provided to providers, monetary or otherwise, for withholding medically necessary services. The Plan shall provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enroll to obtain one outside the network, at no cost to the enrollee.

The Plan shall provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist.

Plans shall be required to cooperate with the City of Charlotte to develop the infrastructure necessary to serve those geographic locations most heavily populated by Medicaid Members. The Plan must provide the Division at least thirty (30) days notice prior to the proposed effective date if it plans to change a location, services, or reduce availability. The Plan must notify in writing those Members affected by such a change at least fifteen (15) business days prior to the effective date of such changes, or as soon as possible in the cases of unforeseen circumstances. The Plan must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

The Plan must provide toll-free telephone medical advice by a licensed medical professional, either directly or through its network providers, to Members twenty-four (24) hours per day, seven (7) days per week. The Plan shall maintain a record of encounters on the telephone medical advice line, including the date of call, type of call, and resolution. The Plan is responsible for educating Members on medical advice procedures.

The Division shall have the right to review periodically the adequacy of service locations, the hours of operation, and the availability and appropriateness of telephone medical advice. The Division may require the Plan to take corrective action to improve member access to services based on periodic reviews.

6.5 Appointment Availability

The Plan must ensure that appropriate services are available as follows:

a. Emergency - immediately upon presentation or notification;
b. Urgent care - within twenty-four (24) hours;
c. Routine sick care - within three (3) days;
d. Well/Preventive care - within ninety (90) days except in the case of a woman who is pregnant, then within fifteen (15) business days;
e. Routine Plan Specialty care - within ninety (90) days;
f. Telephone medical advice – twenty four (24) hours a day and return call to Member within one (1) hour;
g. New Member Health Assessment Encounter - within ninety (90) days of enrollment; except in the case of a woman who is pregnant, then within fifteen (15) business days of enrollment;
h. Child in DSS custody - within seven (7) days; immediately when child is under age two (2) or DSS staff determines the child has chronic or emergent medical need(s).

6.6 Appointment Wait Time

The Plan must agree to provide services within the following wait times:

a. Scheduled appointment - within one (1) hour;
b. Walk-in - within two (2) hours or schedule for subsequent appointment;
c. Life-threatening emergencies - must be managed immediately.

6.7 Member Services

The Plan must staff a Member Services Department to be responsible for:

a. Explaining the operation of the Plan and answering Member questions;
b. Assisting Members in making appointments and in obtaining appropriate services;
c. Assisting Members in securing medically necessary, non-ambulance transportation;
d. Handling Member complaints and providing information on grievance and appeal procedures;
e. Assisting the HBM with providing appropriate Plan information;
f. Resolving claim disputes and processing appeals;
g. Operating a toll free Member Services telephone line to provide information and education during normal business hours.

6.8 Choice of Health Professional

The Plan must have written policies and procedures for assigning each of its Medicaid Members to a Primary Care Provider appropriate to each member's needs. To the extent practical, the Plan must offer freedom of choice to Members in selecting or changing to a different PCP within the Plan, in accordance with its policies for other enrolled groups. However, for an enrollee of a single MCO under paragraph (b)(2) or (b)(3) of section 438.52, any limitation the Division imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitation on disenrollment under 438.56(c). The Plan must agree to assign no more than two thousand (2,000) Members to any one full-time-equivalent provider in its network without the written approval of the Division. The Division encourages the Plan to include among its available providers any county, State, or Federally qualified provider that currently serves Recipients in the service area, including Federally Qualified Health Centers (FQHCs), in-plan school-based health services, and county health departments.

The Plan shall allow children with special needs who utilize Specialists frequently for their health care to maintain these types of Specialists as PCPs, or be allowed direct access to these Specialists for the needed care. A Member who has received prior authorization from the Plan for referral to a Specialist or for inpatient care shall be allowed to choose from among all the available Specialists and hospitals within the Plan, to the extent reasonable and appropriate. The Plan shall implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. The Plan shall implement procedures to coordinate services it furnishes to the enrollee/member with services the enrollee/member receives from any other MCO, Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP). The Plan shall implement procedures to share with other MCOs, PIHPs or PAHPs serving the enrollee/member so that those activities need not be duplicated. The Plan shall implement procedures to share the results of its identification and assessment of the enrollee/member with special health care needs, as defined by the Division, so that these activities need not be duplicated.

6.9 Member Identification Card

The Plan must issue identification cards to Medicaid Members within seven (7) days after the effective date of enrollment. The card may identify the holder as a Medicaid Member through an alpha or numeric indicator, but should not be different in design or color than the card issued to its commercial Members. The card must include the twenty-four (24) hour medical advice telephone number and the toll-free Member services number.

6.10 Facilities and Resources

The Plan must provide directly or by contract the following:

a. Specialists for adult and pediatric care, including care appropriate to children with special health care needs, the elderly, disabled, and adolescent enrollees;
b. Experienced and qualified case management staff;
c. One fully accredited general acute care hospital bed per seven hundred twenty seven (727) enrollees;
d. A designated emergency service facility providing care twenty four (24) hours a day, seven (7) days a week;
e. Facilities at all service locations, which meet the applicable Federal, State, and local requirements, pertaining to health care facilities and laboratories; all laboratory testing sites providing services under the Contract must have either a Clinical Laboratory (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number;
f. Telecommunications system sufficient to meet the needs of the Members;
g. A qualified in-state Plan Administrator;
h. Sufficient support staff;
i. A licensed physician to serve as Medical Director to oversee and be responsible for the proper provision of covered Services to Members;
j. A qualified Quality Assurance director;
k. A data processing person qualified to provide necessary and timely reports and encounter data to the Division.

6.11 Orientation of New Members

The Plan shall provide each new Member, within fourteen (14) days from enrollment, written information on the Plan. All new Member Plan material must be approved by the Division prior to its release, and shall include at least the following information:

a. A list of PCPs, the procedures for selecting an individual physician and scheduling an initial health assessment encounter within the timeframes established in Sections 6.14 and 6.15 of this contract;
b. Procedures for changing PCPs or other practitioners;
c. Information specified in 42 C.F.R. 438.10(f)(6) and 42 C.F.R. 438.10(g);
d. Benefits and services provided and any limitations or exclusions applicable to In-Plan Services;
e. Procedures for notifying Members affected by the termination or change in any benefits, services, service delivery, or office site;
f. Member rights and responsibilities**,** including the right to voluntarily change or disenroll from a health plan, procedures for disenrollment and the right to change PCPs within the Plan;
g. Referral policy for specialty care and a current list of specialty care providers;
h. Provisions for after-hour and emergency care;
i. Role of primary care providers (PCPs);
j. How to access services;
k. The right to formulate Advance Directives;
l. Procedures for obtaining out of area coverage or services;
m. The right to receive family planning services and supplies from Out-of-Plan Providers;
n. Policies regarding the treatment of minors;
o. Any limitations that may apply to services obtained from Out-of-Plan Providers, including a disclosure of the responsibility of Members to pay for unauthorized health care services obtained from Out-of-Plan Providers, and the procedures for obtaining authorization for such services;
p. Circumstances under which a Member may transfer or be involuntarily disenrolled from the Plan;

q. Rights, procedures and timeframes for voicing or filing complaints and grievances or recommending changes in policies and services;
r. Rights, procedures and timeframes for appealing adverse determinations affecting coverage, benefits or enrollment, including the right to appeal directly to the Division;
s. Process for accessing the Health Benefits Manager;
t. Information about the Plan's ability to make reasonable accommodations for people with disabilities;
u. Information concerning transportation arrangements offered by the Plan;
v. Charges to Members.

6.12 Notice to Current Enrollees and Potential Enrollees

The Plan shall have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the Plan. The Plan shall have written policies regarding the enrollee rights specified in 42 C.F.R. 438.100. The Plan must provide information to current enrollees and potential enrollees in their service area concerning:

a. Enrollee rights and responsibilities as set forth in 42 C.F.R. 438.100 and sections referenced therein;
b. The identity, locations, qualifications and availability of health care providers that participate in the Plan;
c. Grievance and appeal procedures;
d. Information on covered items and services;
e. Written information must be made available in the prevalent non-English languages in a particular service area;
f. Availability of oral interpretation service for any language and how to access the service;
g. Availability of interpretation of written information in prevalent languages and how to access those services;
h. Written material must use an easily understood language and format; and be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

All materials must pass current North Carolina readability requirements, G.S. 58-38-1 et. seq. and G.S. 58-67-65 (a)(3).

The Plan must give each enrollee written notice of any " significant" change in the information specified in 42 C.F.R. 438.10(f)(6) and 42 C.F.R. 438.10(g) at least thirty (30) days before the intended effective date of the change. The Division defines significant as changes that require modifications to the State Plan.

6.13 Case Management

The Plan shall be responsible for the management and continuity of medical care for all Members through the following minimum case management functions:

a. Appropriate referral and scheduling assistance for Members needing specialty health care services, including those needing referrals for additional Health Check Services, mental health services, nutritional referrals (WIC), or coordinated medical/social services;
b. Documentation of referral services in each Member's medical record;
c. Monitoring and treatment of Members with ongoing medical conditions according to appropriate standards of medical practice;
d. Documentation in each medical record of all emergency encounters and any medically indicated follow-up care;
e. Coordination of hospital and institutional admissions and discharges, including discharge planning;
f. Coordination of home-based care and home health services;

g. Determination of the need for Out-of-Plan services and referral of Members to the appropriate service setting, utilizing assistance as needed from the Division;
h. The use of multidisciplinary teams to assist in diagnosis and treatment of Members with complex medical needs;
i. The use of care coordination services to assure access to necessary and comprehensive services for children with special health care needs and their families;
j. Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 Subparts A and E, to the extent that they are applicable.

6.14 Case Management Assessment For Children With Special Health Care Needs

Special needs children shall be identified by the Mecklenburg County DSS caseworker at the time of Medicaid eligibility determination. The Division shall identify the Children with Special Health Care Needs (CSHCN) on the monthly enrollment tape sent to the Plan.

The selected Plan must perform a needs assessment for all identified CSHCN by a qualified case manager utilizing a Division approved assessment tool within thirty (30) calendar days of enrollment, or in lieu of completing the assessment, make three (3) documented attempts to do the assessment within a maximum of forty five (45) days from the date of enrollment. If the special needs child is assessed as needing case management, a case manager shall be assigned within five (5) business days after determining the need for case management. The case managers must ensure the development of a comprehensive plan of care and treatment that assures coordination of services and continuity of care as required in 42 C.F.R. 438.208(c)(3).

The Plan must produce a treatment plan for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be:

a. Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;
b. Approved by the Plan, in a timely manner, if this approval is required by the Plan; and
c. In accord with any applicable Division quality assurance and utilization review standards.

The Plan must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 Subparts A and E, to the extent that they are applicable.

In the event that the recipient or responsible party does not select a Plan at the time of enrollment, the special needs child shall be auto-assigned by the HBM. The HBM shall review recent claims history to identify the current provider(s) and the special needs child shall be assigned to the Plan in which their current provider(s) participate(s) if available. If not available, the special needs child shall be assigned to the Plan and provider(s) that is capable of meeting the specific needs of the child.

6.15 New Member Health Assessments

The Plan shall arrange for an initial face to face health assessment visit to new Members within the first ninety (90) calendar days of enrollment, except for the Members listed below. The Division shall review the Plan's success in providing initial face-to-face health assessments within ninety (90) calendar days of enrollment. Should the Division find that the Plan has been unable to meet its obligation, the Plan shall develop a written corrective action plan to identify strategies to increase the number of new Member health assessments.

For Members identified as being pregnant and not having an established relationship with an OB provider, the Plan should request the Member select an OB provider and assist the Member in scheduling an initial prenatal health assessment encounter within fifteen (15) business days of enrollment.

For pregnant Members already established with an OB provider, the Plan should verify via telephone or mail that the Member is indeed receiving prenatal care with the indicated provider. The Plan shall document its efforts to contact each new Member within the first forty-five (45) calendar days of enrollment to schedule the health assessment.

6.16 Family Planning Services

Each Member shall have the right to freely choose a provider or providers of Family Planning Services. Such services may be obtained from Out-of-Plan Providers without a referral or prior authorization from the Plan. Family Planning Services and supplies provided by Out-of-Plan Providers shall be covered by the Plan at fees set by the provider not to exceed the Medicaid allowable rates.

6.17 Health Check (EPSDT) Services

The Plan must have written policies and procedures for providing Health Check (EPSDT) services including lead screenings and immunizations to Members under twenty one (21) years of age. The Plan must comply with all Health Check (EPSDT) regulations set forth in 42 U.S.C. 1396d(r)(5) and 42 U.S.C. 1396d(a), and must submit encounter claims in the format and time frame required by the Division. The Plan is required within sixty (60) days of enrollment, to educate eligible Members and their parents/guardians with materials describing the Health Check screening and its periodicity schedule to encourage compliance. The Plan shall be required to supply provider education to its participating Medicaid providers so as to ensure appropriate understanding of the Health Check screening components, periodicity schedule and billing requirements (i.e., Health Check Billing Guide). The Plan must assure the provision of all required components of health screenings, including lead screenings at twelve (12) and twenty four (24) months of age and children between thirty six (36) and seventy two (72) months if not previously screened for lead; immunizations; health education; and the provision of any treatment or services covered by the State's Medicaid program, necessary to correct or ameliorate defects and physical or mental illnesses and conditions discovered during screening services. The Scope of Health Check (EPSDT) Services is outlined in Appendix IV and the April 2003 Medicaid Health Check Special Bulletin listed in Appendix XIII of this contract. The Plan has the option of providing Health Check services directly or contracting with the County Health Department, School Based Health Centers, or other qualified providers.

6.18 Health Education Services

The Plan shall make available on an on-going basis the following health education services at convenient times, in accessible locations, and at no cost to Medicaid Members:

Childbirth Education Classes: Offer parents the opportunity to develop knowledge and skills about the maternity cycle, delivery process, and initial information about newborn care.

Parenting Classes: Provided to expectant and new parents. The classes shall provide general information about parenting skills and care of infants and children. Classes should include topics such as bathing, feeding (including breast-feeding), injury prevention, sleeping, illness, preventive care, screening recommendations, and when to call a medical provider.

Child Development Classes: Provide parents the opportunity to learn about the normal stages of child growth and development.

Diabetes Self-Care Instruction: The Plan must provide for the assessment of skills, knowledge, and attitude for all Members who have been diagnosed with either Type I or II Diabetes. The Plan must develop a plan of care that addresses the specific and unique health care needs of the diabetic Member, including the need for specific training and education in the management of Diabetes and the possible need for referral.

Asthma Self-Management: The Plan must provide for the assessment of skills, knowledge, and attitude for all Members who have been diagnosed with chronic asthma. The Plan must develop a plan of care that addresses the specific and unique health care needs of the asthmatic Member, including the need for specific training and education in the management of asthma and the possible need for referral.

Nutrition Services: The Plan must agree to incorporate comprehensive nutrition assessments, education, and counseling for all Members. The Plan must provide follow-up or referral to any Member who has a diagnosis or risk factors for which nutrition therapy is a critical component of medical management.

The Plan shall keep a log of Members referred to health education services.

6.19 Support Services

The Plan shall develop strategies for addressing the special needs of the Medicaid population. Strategies should incorporate the use of staff training to increase awareness and sensitivity to the needs of persons who may be disadvantaged by low income, disability and illiteracy, or who may be non-English speaking. Staff training should include topics such as sensitivity to different cultures and beliefs, the use of bilingual interpreters, the use of Relay NC, TTY machines, and other communication devices for the disabled, overcoming barriers to accessing medical care, understanding the role of substandard housing, poor diet, and lack of telephone or transportation for health care needs.

The Plan shall provide the following services as necessary to ensure Member access to and appropriate utilization of medically necessary services covered under this Contract:

Transportation: The Plan shall assist with the arrangement of non-emergency transportation for its Members through available public and private services. The Plan shall provide Members with written information concerning transportation arrangements offered by the Plan. The Plan shall document the provision of transportation services to any Member requiring such assistance.

Interpreter Services: Interpreter services shall be made available by telephone, or in-person to ensure that Members are able to communicate with the Plan and providers**.** The Plan must make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the Division has identified as prevalent.

Coordination and Referral to Community Resources: The Plan shall provide referral to available community services, including but not limited to those identified in Appendix VI. The Plan shall have staff who are familiar with these resources and shall maintain a written description of appropriate referral procedures.

Referral to the WIC Program: Pursuant to Public Law 103-448, 204(e), the Plan shall ensure coordination with the WIC Program, described in Appendix VI. This coordination should include the referral of potentially eligible women, infants, and children to the WIC Program and include the provision of medical information from the Plan provider to the WIC Program.

6.20 Referrals for Out-of-Plan Services

The Plan shall ensure that Members are referred for all medically necessary services, both in-plan and out-of-plan. The Plan must consult with the County DSS when referring Members to long term institutional services such as those provided by nursing facilities, hospital swing bed units, intermediate care facilities for the mentally retarded or mentally ill, or to the Community Alternatives Program, as described in Appendix VI. The Plan shall have written policies and procedures for the referral of Members for Out-of-Plan services. These procedures shall be applicable to the appropriate referral of Members upon disenrollment from the Plan, regardless of the reason for disenrollment.

6.21 Payment to Out-of-Plan Providers

The Plan shall reimburse Out-of-Plan Providers for Covered Services, which may be obtained by Members without prior authorization from the Plan for the following:

a. Emergency medical services which could not be provided by the Plan because the time to reach the Plan Provider capable of providing such services would have meant risk of serious damage or injury to the Member's health. The Plan shall consider each claim for reimbursement for emergency medical services provided to Members by Out-of-Plan Providers based upon its own merits and the requirements of this Section, and shall not routinely deny such claims based upon failure to obtain prior authorization;
b. Medicaid covered family planning services and supplies;
c. Services provided by a Public Health Department for the screening, diagnosis, counseling, or treatment of STD's, TB, HIV, or family planning services. In the absence of a contractual arrangement with the Public Health Department, the Plan must pay for the service at fees set by the provider not to exceed the Medicaid allowable rates.

The Plan must coordinate payment with out-of-plan providers and ensure that the cost to an enrollee is no greater than it would be if the services were furnished within the network.

The Member may be required to complete an Out-of-Plan claim form to assist in proper and prompt payment of services. The Plan shall describe in writing the procedures whereby Out-of-Plan Providers can appeal claims denied by the Plan.

6.22 Advance Directives

The Plan shall maintain written policies and procedures concerning Advance Directives. The Plan shall distribute information regarding Advance Directive policies to adult enrollees, including a description of applicable State and Federal laws as outlined in Medicaid Special Bulletin on Advance Directives, May 1999 (See Appendix XIV). The information distributed must reflect changes in laws as soon as possible, but no later than ninety (90) days after the effective date of the law.

6.23 Members with Third Party Coverage

Members with third party coverage may obtain Covered Services from Out-of-Plan providers, without obtaining prior approval from the HMO. The Plan is responsible for reimbursing any co-payments or deductibles to the provider as follows:

a. The Plan is liable for assuring payment up to the Medicaid fee-for-service maximum allowable payment. If the third party payment is equal to or exceeds the Medicaid allowable, neither the Plan nor the member is responsible for payment of any co-payments billed by the provider;
b. Neither the Plan nor the Member is responsible for payment to any provider who does not accept Medicaid reimbursement as payment in full.

6.24 Payments From Members

The Plan may not require co-payments, deductibles, or other forms of cost sharing from Members for services covered under this Contract, nor may the Plan charge Members for missed appointments. Members who obtain services from Out-of-Plan Providers without Plan authorization, except those services specified in Sections 6.3, 6.16, 6.20, and 6.21 shall be responsible for payment of costs associated with such services. The Plan shall include on all Member identification cards a Member Services telephone number, which may be used by Out-of-Plan Providers to obtain referral and billing information. Any cost sharing imposed on members shall be in accordance with 42 CF.R. 447.50 through 42 C.F.R. 447.60 (same as permitted in Fee for Service (FFS)).

Members may not be held liable for payments to providers or entities:

a. In the event of the HMO's or subcontractor's insolvency;
b. In the event that the Division does not pay the Plan;
c. For payments under an arrangement with the Plan in excess of the amount that would be owed if the Plan directly provided the services.

6.25 Inpatient Hospital Services

The Division shall be responsible for reimbursement of inpatient hospital services provided to Recipients who are inpatients prior to the effective date of their enrollment in the Plan, until such Recipient is discharged from the hospital. For Recipients who are inpatients prior to the effective date of their enrollment in the Plan, the Plan shall provide all Covered services, except inpatient and related inpatient services. For Recipients hospitalized on or after the effective date of enrollment in the Plan, the Plan shall provide all covered services, including inpatient and related inpatient services. The Plan shall provide all Covered Services, except inpatient and related inpatient services, to hospitalized Members commencing on the effective date of enrollment. The Plan shall provide all Covered Services (including inpatient hospital services) to newborn infants of female Members until such infant is discharged from the hospital, and shall continue to provide all inpatient hospital services to Members who are hospitalized on the effective date of disenrollment (whether voluntary of involuntary) until such Member is discharged from the hospital.

6.26 Maternity Length of Stay

Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than forty eight (48) hours for both the mother and the newborn child. Health coverage for a hospital stay in connection with childbirth following a Cesarean Section may not be limited to less than ninety six (96) hours for both the mother and the newborn child.

6.27 Therapeutic Abortions

The Plan must have written policies and procedures in place to assure that abortions and abortion related services provided to Members are only reimbursed by the Plan for the following federally approved reasons:

a. The pregnancy is the result of rape;
b. The pregnancy is the result of incest;
c. The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Abortion related services are defined as:

a. Physician/surgical charges for performing the abortion. These charges include the usual, uncomplicated pre and postoperative care and visits related to performing the abortion;
b. Hospital or clinic charges associated with the abortion. This includes the facility fee for use of the operating room, supplies, and drugs necessary to perform the abortion and charges associated with routine, uncomplicated pre and postoperative visits by the patient;
c. Physician charges for administering the anesthesia necessary to induce or perform an abortion;
d. Drug charges for medication usually provided to or prescribed for the patient who undergoes an uncomplicated abortion. This includes routinely provided oral analgesics and antibiotics to prevent septic complication of abortion, and Rho-GAM (an immune globulin administered to RH-negative women who have an abortion);

e. Charges for histo-pathological laboratory tests performed routinely on the extracted fetus or abortion contents;
f. Charges for other laboratory tests performed prior to performing the nonmatchable abortion to determine the anesthetic/surgical risk of the patient (e.g., CBC, electrolytes, blood typing).

Certain specific services for an abortion, if performed for reasons other than the federally approved reasons listed above, may be reimbursed by the Plan if those services would have been performed on a pregnant woman regardless of whether she was seeking an abortion. Those services include:

a. Charges for pregnancy tests which would have been performed whether or not the individual was seeking an abortion;
b. Charges for tests to identify sexually transmitted diseases (e.g., Chlamydia, Gonorrhea and Syphilis) and other laboratory tests routinely performed on a pregnant patient, such as Pap smear and urinalysis;
c. Charges for all services, tests and procedures performed post-abortion for complications of a non-Federally funded therapeutic abortion, including charges for a hospital stay beyond the normal length of stay for abortions and charges for services following a septic abortion, etc.

The Plan must have policies and procedures in place to ensure that federal and state abortion guidelines are followed. Please refer to the September 1998 Special Medicaid Bulletin referenced in Appendix XIII and C.F.R. 42 Subpart E 441.200 through 441.208.

The Plan must obtain the required State-approved abortion statement prior to paying for any therapeutic abortion. The abortion statement documents must be kept on file in the Plan's office for a period of five years.

6.28 Sterilization and Hysterectomy Requirements

The North Carolina Medicaid Program is bound by stringent federal guidelines in regard to coverage of sterilization procedures. The sterilization consent form is a federally mandated document that must be kept on file in accordance with federal regulations in 42 C.F.R. 441.250-441.259. All federal regulations pertaining to the completion of the form must be satisfied prior to the procedure being performed.

Please refer to the April and June 2000 Medicaid Bulletin articles referenced in Appendix XIII for Medicaid requirements regarding sterilization. The Plan must keep the signed consent form on file in their office for five years.

Medicaid policy and procedure must be followed when performing a hysterectomy, please refer to the Hysterectomy Guidelines Handout listed in Appendix XIII and 42 C.F.R. 441.255. The Plan must have policies and procedures in place to ensure that one of three federally approved hysterectomy statements that is required prior to payment of a hysterectomy claim is obtained. The required statement must be kept on file in the Plan's office for a period of five years.

6.29 Nursing Facility Services

The Plan is responsible for providing nursing facility services to their enrolled Members for no more than thirty (30) consecutive days. When a recipient enters a nursing facility, the Plan must notify DSS and the Division in writing, including the admission date and intended length of stay. Upon such notification, the Division shall make the appropriate enrollment changes.

6.30 Traumatic Brain Injury (TBI)

The Plan is responsible for the first $10,000 of paid claims for TBI Members. Once the Plan has accumulated $10,000 of paid claims, the Plan must notify the Division in writing that it has met the threshold and must include supporting documentation.

TBI Members who receive care from a nursing facility (head level of care) are not the Plan's responsibility. However, there may be circumstances when an enrolled member experiences a traumatic brain injury and begins receiving nursing facility services (head level of care). In these cases, it is the Plan's responsibility to notify the Division immediately, so that the Medicaid recipient shall be made fee-for-service retroactively to the first day of the month in which the nursing facility head level of care services began.

6.31 Ventilator Dependent Care

The Plan is not responsible for providing services to ventilator dependent inpatient Medicaid Recipients. It is the Plan's responsibility to notify the Division in writing when an enrolled member becomes ventilator dependent or when a person who is ventilator dependent inadvertently becomes an enrolled member. The Division defines Recipients who are ventilator dependent as those who are receiving ventilator care services at a hospital or nursing facility (including swing beds).

Once the Division has received notification of the recipient's ventilator dependency and has reviewed the supporting documentation submitted by the Plan, then the recipient shall be made fee-for-service retroactively to the first day of the month in which the ventilator dependency has been documented.

6.32 Injectable Drugs

According to Section 6.2, Covered Services and as set forth in this contract, of this contract the Plan is to "provide to Recipients enrolled under this Contract, directly or through arrangements with others, all of the Covered Services identified in Appendix III." Covered Services are defined in the respective Medicaid Provider Manual and Bulletins, which are incorporated herein by reference. In Appendix III of the contract (Schedule of Benefits), Inpatient Hospital - except for Mental Health and Substance Abuse, and Outpatient Hospital are listed as In-Plan Benefits.

Drugs and biologicals for use in the hospital are considered to be covered services. Outpatient services coverage is extended to drugs and biologicals used by physicians or hospital personnel in the treatment of outpatients. Injectable drugs are covered by this provision.

Medications provided in the course of outpatient treatment, including injectable drugs, are considered covered services within this contract and included in the calculation of the capitation rates. When calculating the rates for the outpatient services, medicines used in those services were taken into account, and are properly reflected in the rates. The capitation rate covers the medications used in covered services, therefore the Plan is responsible for the costs of these medications.

Pharmacy is distinguished from medications used in treatment by determining if the recipient receives a prescribed order (prescription) for prescription drugs that the recipient can take out of the hospital to have filled. The recipient can also have the prescribed order filled by the hospital's pharmacy. In these situations, Medicaid would be billed directly for pharmacy. In summary, medications provided in the course of inpatient and outpatient services are covered in the Plan's capitation rate. To separate these medications out and bill them directly to Medicaid is inappropriate, and any such claims shall be denied.

6.33 Children's Special Health Services

Children's Special Health Services are included in the Plan's capitation rates and are considered in-plan services, (see Medicaid Durable Medical Equipment (DME) Manual for services). In circumstances necessitating extensive DME, the Plan shall review for medical necessity and pay on a case-by-case basis. As an in-plan benefit, the review for medical necessity is performed by the Plan and should be reimbursed accordingly.

6.34 Laboratory Services Provided to Mental Health Patients

Laboratory services are an in-plan benefit and included in the capitation rate, therefore, the Plan is responsible for the reimbursement of all laboratory services provided to its Members enrolled through the Medicaid Program. These laboratory services may include tests done for the purpose of monitoring the physical health of a patient who has been prescribed medications for the treatment of mental illness or other condition.

6.35 Anti-Gag Rule Provision

The Plan shall not prohibit or otherwise restrict health care professionals from advising beneficiaries about their health status, medical care, or treatment regardless of benefit coverage if the professional is acting within their scope of practice. This provision does not require the Plan to cover counseling or referral service if it objects on moral or religious grounds and makes available information on its policies to enrollees and potential enrollees within thirty (30) days of a policy change regarding such counseling or referral services.

6.36 Confidentiality

Information about Medicaid Recipients, Medicaid applicants and provider eligibility, or the amount of assistance and services provided is confidential as defined by Federal and State law or by Division policy. The Plan must establish and implement policies and procedures consistent with confidentiality requirements of the HIPAA rule found in 45 C.F.R. Parts 160 and 164. Information must be made available for purposes directly connected with the administration of the program to include access to medical records for the purposes of quality management when requested in writing by the Division or its authorized designee.

SECTION 7 - QUALITY ASSURANCE and QUALITY IMPROVEMENT

7.1 Internal Quality Assurance/Performance Improvement Program

The Plan shall establish and maintain a written program for Quality Assurance/Performance Improvement ("QA/PI") consistent with 42 C.F.R. 434.34 and 42 C.F.R. 438.240 and with the utilization control program required by CMS for the Division's overall Medicaid program as described in 42 C.F.R. 456.

The Plan shall submit the written Quality Assurance/Performance Improvement program description and a summary of progress toward performance improvement goals to the Division on an annual basis no later than June 30th of each calendar year.

The written program must describe, at a minimum, how the Plan shall:

a. Achieve CMS and/or Division or Plan defined minimum performance levels on standardized quality measures annually. (See Appendix XVIII for Benchmark Performance Levels);
b. Develop and implement performance improvement projects using data from multiple sources that focus on clinical and non-clinical areas. These projects must achieve, through ongoing measurements and intervention, demonstrable and sustained improvement in

significant aspects of care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction;

c. Have in effect mechanisms to detect both over and under utilization of services;
d. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs;
e. Have a comprehensive scope that assures all demographic groups, care settings, and types of services are included in the scope of the review occurring over multiple review periods;
f. Measure the performance of Plan providers and conduct peer review activities such as identification of practices that do not meet Plan standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by providers;
g. Measure provider performance through inclusion of medical record audits;
h. Provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the Plan;
i. Develop and/or adopt clinically appropriate practice parameters and protocols/guidelines and provide the Plan's providers enough information about the protocols/guidelines to enable them to meet the established standards;
j. Evaluate access to care for Enrollees according to established standards and those developed by the Plan and implement a process for ensuring that network providers meet and maintain the standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities.

1. The Plan shall develop, implement, and report to the Division a minimum of two (2) plan-specific and self-funded performance improvement projects the first year of this contract: one focusing on a clinical area and one focusing on a non-clinical area. The topics for these projects shall be jointly determined by the Plan and the Division based on statistical reports submitted to the Division the previous year**.** Progress summaries of these projects shall be submitted to the Division by June 30 of each calendar year. (See Appendix V and XVI). For year two of this contract, the Plan shall conduct a performance improvement project in addition to the two planned for the first year of this contract for a total of three. For year three of the contract, the Plan shall conduct an additional performance improvement project for a total of four. The project topics shall be jointly determined by the Plan and the Division unless mandated by CMS and based on Plan performance as measured by annual reporting to the Division;
2. The plan, at its own expense, shall participate annually in at least one (1) statewide performance improvement project. (See Appendix V);
3. The Plan shall conduct an annual Consumer Assessment of Health Plan Survey (CAHPS), utilizing the sampling and format as defined by NCQA. The results of the survey must be filed with the Division as stated in Appendix V, Statistical Reporting Requirements;
4. The Plan shall maintain an active QA/PI committee or other structure, which shall be responsible for carrying out the planned activities of the Quality Assessment/Performance Improvement program. This committee shall have regular meetings, shall document attendance by providers, and shall be accountable and report regularly to the governing board or its designee concerning QA/PI activities. The Plan shall maintain records documenting the committee's findings, recommendations, and actions;
5. The Plan shall designate a senior executive who shall be responsible for program implementation. The Plan's Medical Director shall have substantial involvement in the QA/PI program functions, such as credentialing and utilization review and review and monitoring of its subcontractors.

7.2 <u>Annual External Quality Reviews</u>

Pursuant to 42 C.F.R. 438 Subpart E, the Division shall conduct annual medical audits to ensure the provision of quality and accessible health care; identify and collect management data for use by medical audit personnel, and provide data that includes information on use of services and reasons for enrollment and termination. In addition, the Division shall contract with a utilization and quality control peer review organization or private accreditation body to conduct an annual independent external review of the quality of services furnished under this Contract.

7.3 Inspection and Monitoring

The Division shall monitor the Plan's enrollment and disenrollment practices and shall insure the proper implementation of the Plan's grievance procedures, in accordance with 42 C.F.R. 438.66.

Pursuant to 42 C.F.R. 438.6(g), the Division, the United States Department of Health and Human Services (HHS) and any other authorized Federal or State personnel or their authorized representatives may inspect and audit any financial records of the Plan or its subcontractors relating to the Plan's capacity to bear the risk of potential financial losses.

Pursuant to 42 C.F.R. 434.6(a)(5), and as otherwise provided under this Contract, the Division, HHS and any other authorized Federal or State personnel or their authorized representatives shall evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under this Contract.

Such monitoring activities may include on-site inspections of all service locations and health care facilities; financial and medical audits; review and reproduction of any records developed under this Contract; review of management systems, policies and procedures; and review of any other areas or materials relevant to or pertaining to this Contract. The Division shall retain the right to develop monitoring tools to carry out inspections. The Division shall provide the Plan with a report of its findings and recommendations, and may require the Plan to develop corrective action plans as appropriate.

The Plan shall implement timely access monitoring as follows:

a. establish mechanisms to ensure that network providers comply with the timely access requirements;
b. monitor regularly to determine compliance;
c. take corrective action if there is a failure to comply.

7.4 Utilization Management

The Plan shall have a written utilization management program that is consistent with 42 C.F.R. 456 and includes mechanisms to detect underutilization as well as over utilization of services. The written description shall address procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.

7.5 Grievance/Complaint Procedure

The Plan shall have a timely and organized system with written policies and procedures for resolving internal grievances in accordance with 42 C.F.R. 438.228, 42 C.F.R. 438 Subpart F, and the requirements set forth in Appendix IX, that:

a. Is approved in writing by the Division;
b. Provides for prompt resolution; and
c. Assures the participation of individuals with the authority to require corrective action.

Tracking and analysis of transfers, complaints, and grievance data shall be used by the Plan for quality improvement. All Medicaid Member grievances, complaints, and appeals must be reported by number and type and with action taken for resolution. Reports must be submitted no later then forty five (45) calendar days after the end of a calendar quarter. The Plan must comply with requirements for grievance procedures and reporting in Appendix V Statistical Reporting and Appendix IX Grievance Procedures.

7.6 Credentialing

The Plan shall have written policies and procedures for provider credentialing and recredentialing to identify providers who fall under its scope of authority and action and shall adhere to such polices and procedures. The Plan shall demonstrate that its providers are credentialed by providing the Division a copy of their policies and procedures. The Division shall review the Plan's provider credentialing and recredentialing process during the annual independent external review. The policies and procedures established by the Plan to verify and document provider credentials shall comply with all applicable State and Federal credentialing and recredentialing polices, requirements and regulations, including but not limited to, credentialing and recredentialing requirements as determined by the North Carolina Department of Insurance.

7.7 Provider Selection

The Plan shall have written policies and procedures for the selection and retention of providers. The Plan shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Plan declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

In all contracts with health care professionals, the Plan must comply with the requirements specified in 42 C.F.R. 438.214 which includes, selection and retention of providers, credentialing and recredentialing requirements and nondiscrimation. The Plan shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Plan shall not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128 A of the Social Security Act. The Plan shall consult the Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities (LEIE), the Medicare Exclusion Databases (MED) or the Excluded Parties Listing System (EPLS) to ensure that providers who are excluded from participation in Federal programs are not enrolled in the Plan network.

The Plan is not required to contract with providers beyond the number necessary to meet the needs of its enrollees.

The Plan is not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

7.8 Health Information Systems

The Plan must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

The Plan must collect data on enrollee and provider characteristics as specified by the Division, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the Division. The Plan must make all collected data available to the Division and upon request to CMS.

The Plan must ensure that data received from providers is accurate and complete by:

a. Verifying the accuracy and timeliness of reported data;
b. Screening the data for completeness, logic, and consistency; and
c. Collecting service information in standardized formats to the extent feasible and appropriate.

SECTION 8 - RECORDS

8.1 Medical Records

The Plan shall set standards for medical records, which reflect all aspects of patient care, including ancillary services. The Plan shall monitor the medical record documentation to ensure that the standards are met. These standards, at a minimum, shall provide for the following:

a. Each page or electronic file in the record contains the patient's name or patient ID number;
b. Personal and biographical data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status;
c. All entries are dated;
d. All entries are identified as to the author;
e. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies;
f. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth;
g. The record is legible to someone other than the writer;
h. There is a completed immunization record. For pediatric records (ages twelve (12) and under) there is a completed record with dates of immunization administration;
i. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record;
j. Notation concerning smoking, alcohol, and other substance abuse is present for patients' age twelve (12) and over at the first routine visit;
k. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart has the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans;
l. Emergency care is documented in the record;
m. Discharge summaries are included as part of the medical record for all hospital admissions which occur while the patient is enrolled in the Plan; and
n. Documentation of individual encounters which provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic tests, therapies, and other prescribed regimen, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.

8.2 Confidentiality of Records

The Plan shall comply with the requirements of 42 C.F.R 431 Subpart F and 45 C.F.R. Parts 160 and 164, to restrict the use or disclosure of information concerning Members to purposes directly related to the performance of its duties and securement of its rights under this Contract. The Division, the State Attorney General's Office, the State Audit Department, authorized Federal or State personnel, or the authorized representatives of these parties including, without limitation, any employee, agent, or contractor of the Division, CMS, and the Department of Health and Human Services, shall have access to all confidential information in accordance with the requirements of this Contract and State and Federal law and regulations pertaining to such access.

8.3 Access to Records

Any records requested pursuant to monitoring, audit or inspection as called for in this Contract shall be produced immediately for on-site review or sent to the requesting authority by mail within fourteen (14) days following the request. All records shall be provided at the sole cost and expense of the Plan. The Division shall have unlimited rights to use, disclose, and duplicate information and data developed, derived, documented, or furnished by the Plan and in any way relating to this Contract.

8.4 Maintenance of Records

The Plan or Plan Providers shall maintain detailed records of the administrative costs and expenses incurred pursuant to this Contract including provision of Covered Services and all relevant medical information relating to individual Members, for the purpose of audit and evaluation by the Division and other Federal or State personnel. All records shall be maintained and available for review by authorized Federal and State personnel during the entire term of this Contract and for a period of five (5) years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, records shall be kept until all issues are finally resolved.

8.5 Transfer of Medical Records

The Plan shall transfer enrollee medical records to a new Managed Care Organization (MCO)/Primary Care Provider (PCP) upon request and when authorized by the enrollee in writing within thirty (30) days of the request to provide for continuity of care as pursuant to Federal and State Law or Division policy.

SECTION 9 - REPORTS AND DATA

9.1 Enrollment Report

The Division shall provide to the Plan an Enrollment Report, on or before the first (1st) day of each month, listing all Recipients who are Members of the Plan for that month. All enrollments and disenrollments shall be effective on the first day of the calendar month for which the enrollment or disenrollment is listed on the Enrollment Report. The Enrollment Report shall serve as the basis for capitated payments to the Plan for the ensuing month. The Plan shall reconcile the Enrollment Report against its internal records within ten (10) business days and shall notify the Division of any discrepancies. Adjustments shall be made to the next enrollment report reflecting corrections reported to the Division on or before the fifteenth (15th) day of each month.

9.2 Encounter Data

The Plan must submit to the Division one hundred percent (100%) encounter data within one hundred and eighty (180) days from the end of the month in which the service was rendered. The data must be submitted electronically according to ANSI standards using the HCFA-1500, UB-92, and American Dental Association claim formats. Refer to Appendix X and the North Carolina HMO Risk Contracting Encounter Data Submission Manual for Encounter Data minimum reporting requirements and National Standard Format (NSF) compliance guidelines. The Division shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. The Plan must report all encounters that occur up to the date of termination. If the contract terminates while the Plan is in withhold status due to inaccurate or late reporting of encounter data, the Division shall continue the withhold until the Plan reports all encounter data according to the Division's encounter data policy.

9.3 Reporting Requirements

The Plan shall comply with the reporting requirements set forth by the Division, including data submission to verify claims payment as described in Section 12.2. The Division shall furnish the Plan with timely notice of reporting requirements, including acceptable reporting formats, instructions, and timetables for submission and such technical assistance in filing reports and data as may be permitted by the Division's available resources. The Division reserves the right to modify from time to time the form, content, instruction, and timetables for collection and reporting of data. The Plan shall send a representative to Data Advisory Meetings sponsored by the Division, held no more often than quarterly. The Division agrees to involve Plans in the decision process prior to implementing changes in format, and shall request Plans to review and comment on format changes before they go into effect. Plans shall be given sixty (60) days to comply with new requests.

In the event that the Plan fails to submit any data or report required pursuant to this Section, the Division shall have the right to withhold up to ten percent (10%) of the subsequent months' capitation payments, pending receipt of the respective data or report by the Division. The Division shall have the right to assess penalties, pursuant to Section 12.2, Timeliness of Provider Payments and SECTION 14, PENALTIES; in addition to the ten percent (10%) withhold of the subsequent month's capitation payment in the event the Plan does not pay providers in the time frames specified in 42 C.F.R. 447.45.

Physicians who provide services under the Contract must have a unique identifier.

9.4 Fraud and Abuse

The Plan must have administrative and management arrangements or procedures designed to guard against fraud and abuse. The Plan arrangements and procedures must include the following:

a. A procedure to verify whether services reimbursed by Medicaid were actually furnished to Recipients by providers and subcontractors;
b. Written policies, procedures, and standards of conduct the articulate the organization's commitment to comply with all applicable Federal and State standards;
c. The designation of a compliance officer and a compliance committee that are accountable to senior management;
d. Effective training and education for the compliance officer and the organization's employees;
e. Effective lines of communication between the compliance officer and the organization's employees;
f. Enforcement of standards through well-publicized disciplinary guidelines;
g. Provision for internal monitoring and auditing;
h. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Plan's contract.

The Plan must have a mandatory compliance plan designed to guard against fraud and abuse. If the Plan receives a complaint of fraud and abuse from any source or identifies any questionable practices, it must forward the information to the Division. For each case of suspected provider fraud and abuse the Plan must provide the Division with the provider's name and number, the source of the complaint, the type of provider, the nature of the complaint, the approximate range of dollars involved, and the legal and administrative disposition of the case. For each case of suspected recipient fraud and abuse the Plan must provide the Division with the recipient's name and number, and the source and nature of the compliant. The Division shall conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

9.5 Financial Reports

Within sixty (60) days of the end of each calendar year quarter, financial data shall be reported on total revenue, expenses, overall loss ratio, medical loss ratio, gross margin, administrative loss ratio, operating profit after corporate expenses for most recent completed quarter and forecasted quarters (modified HEDIS). The Plan shall within ten (10) days of filing the National Association of Insurance Commissioners (NAIC) Annual Statement, HMO Edition, with the North Carolina Department of Insurance, file a copy of said statement with the Division. The Plan shall within ten (10) days of filing the NAIC Quarterly Statement with the North Carolina Department of Insurance, file a copy of said document with the Division of Medical Assistance. The Plan shall file within sixty (60) days of the end of each calendar quarter reports including, but not limited to: Balance Sheet, Statement of Revenue, Expenses and Net Worth, Cash Flow Statement, Enrollment and Utilization Table, Number of High Cost Patients, and Incurred but not Reported Statement Expenses. These forms may be obtained from the Division of Medical Assistance.

The Plan shall accept the capitation rate paid each month by the Division as payment in full for all services to be provided pursuant to this Contract, including all administrative costs associated therewith. A minimum of eighty-five percent (85%) of all the Plan's income generated under this Contract, including but not limited to Third Party Recoupments and Interest, shall be expended on the medical and related services required under this Contract to be provided to the Plan's Medicaid Members. If the Plan does not expend a minimum of eighty-five percent (85%) on medical and related services of the Contract, the Division shall withhold an amount so that the Plan's ratio for service expenditures are eighty-five percent (85%). The Division shall calculate the Plan's income at the end of the State Fiscal Year to determine if eighty-five percent (85%) was expended on the medical and related services required under the contract. Administrative costs and other financial information shall be monitored on a regular basis by the Division.

9.6 Data Certification

All information, reports and data, including but not limited to encounter data, which this contract requires the Plan to submit the Division must be certified as set forth in 42 C.F.R. 438.606. The certification must be made by one of the following individuals:

a. The Plan's Chief Executive Officer;
b. The Plan's Chief Financial Officer; and
c. An individual who has delegated authority to sign for, and who reports directly to, the Plan's Chief Executive Officer or Chief Financial Officer.

The certification must attest based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The Plan must submit the certification concurrently with the certified data and documents.

SECTION 10 - PAYMENTS TO THE PLAN

10.1 Monthly Payment

In full consideration of all services rendered by the Plan under this Contract, the Division shall remit to the Plan the capitation rate specified in Appendix XI for each Member listed on the Enrollment Report issued for that month, on or before the tenth (10th) day of each month. However, payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements 42 C.F.R. 438.730.

In accordance with the rate setting methodology, a person is considered a year older on the first day of the month of their birthday, regardless of the person's day of birth. For example, a person born August 30, 2002 shall be considered 1 year old on August 1, 2003. The Plan shall be paid the Newborn rate through July, then in August the Age 1-5 rate shall begin. As Members transition into different rate bands due to age, the new rate is effective on the first of the month in which the person was born.

The payment is contingent upon satisfactory performance by the Plan of its duties and responsibilities as set forth in this Contract. All payments shall be made by electronic funds transfers. The Plan shall set up the necessary bank accounts and provide written authorization to the Division's Fiscal Agent to generate and process monthly payments through the internal billing methods, in form and substance designated by the Division.

10.2 Payment in Full

The Plan shall accept the capitation rate paid each month by the Division as payment in full for all services to be provided pursuant to this Contract, including all administrative costs associated therewith. A minimum of eighty-five percent (85%) of all the Plan's income generated under this Contract, including but not limited to Third Party Recoupments and Interest, shall be expended on the medical and related services required under this Contract to be provided to the Plan's Medicaid Members. If the Plan does not expend a minimum of eighty-five percent (85%) on medical and related services of the Contract, the Division shall adjust payments to withhold an amount so that the Plan's ratio for service expenditures are eighty-five percent (85%). The Division shall calculate the Plan's income at the end of the State Fiscal Year to determine if eighty-five percent (85%) was expended on the medical and related services required under the contract. Administrative costs and other financial information shall be monitored on a regular basis by the Division.

Members shall be entitled to receive all covered services for the entire period for which payment has been made by the Division. Any and all costs incurred by the Plan in excess of the capitation payment shall be borne in full by the Plan. Interest generated through investment of funds paid to the Plan pursuant to this Contract shall be the property of the Plan.

10.3 Payment Adjustments

Monthly capitation payments shall be adjusted to reflect corrections to the Enrollment Report issued for the preceding month, provided the Division is notified of discrepancies by the fifteenth (15th) day of the current month. Payments shall be adjusted to reflect the automatic re-enrollment of reopened cases for Recipients covered under Section 1931 of the Social Security Act (1931 Group) and the automatic enrollment of eligible newborns. Failure to request a payment adjustment within the time limit specified in this Section shall not relieve the Plan of its obligations to provide coverage pursuant to this Contract.

Payment adjustments may be initiated by the Division when keying errors or system errors affecting correct capitation payments to the Plan occur. Each payment adjustment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying Member information and the payment adjustment amount.

10.4 Calculation of Rates

The Plan and the Division shall negotiate capitation rates in good faith. These rates shall be certified as compliant with the Centers for Medicare and Medicaid Services requirements under 42 C.F.R. 438.6(c) by actuaries meeting the qualification standards of the American Academy of Actuaries.

The actuary for the Division shall develop capitation rate ranges in accordance with generally accepted actuarial practices and principles for the populations and services covered under the managed care contract. The Division reserves the right to determine and/or adjust these populations and services covered under this contract prior to each year.

Each year the basis for capitation rate development shall be the historical costs incurred by the Division in providing Covered Services (excluding expanded services) on a fee-for-service (FFS) basis to non-enrolled Recipients in each eligibility group, for each Medicaid HMO program area, during one or more fiscal years ending one year prior to the first day of the next fiscal year (base period). The Division shall rebase the rates every three years. Appropriate adjustments to the base period shall include deducting amounts recovered from third party resources, adjusting costs to account for changes in benefits and payment levels subsequent to the base period and applying appropriate trend factors (to be determined by the Division) to project base period costs into the renewal term. Managed care adjustments shall be applied to the base period costs to account for variations in the health care delivery patterns between managed care and FFS. Where necessary, smoothing techniques to reflect expected changes in medical practice patterns between managed care and FFS by rate cell shall be applied. The

overall impact of relational modeling across the managed care program shall be budget neutral. The final adjustment made to the capitation rates shall represent a margin for MCO administration, risk, and profit.

Appendix XI indicates projected and maximum authorized enrollment levels and the capitation rates applicable to each Member group for the initial year of this Contract. Using this methodology, rates shall be recalculated each year and the Plan shall be notified by June 1 of the new rates to be effective October 1 of the next year. The Plan shall have sixty (60) days to review the proposed rates. At the end of the sixty (60) day review period the Plan may choose to terminate the contract with the Division. The Plan shall be required to provide a sixty day (60) written notification to avoid incurring liquidated damages.

10.5 Rate Adjustments

The Plan and the Division acknowledge that the capitation rates and calculation methodology are subject to approval by CMS. Prospective adjustments to the rates may be required. The rate of payment and total dollar amount shall be adjusted pursuant to a properly executed amendment when Medicaid fee-for-service expenditure changes have been established through the appropriations process, and subsequently identified in the Division's operating budget. Legislatively mandated changes shall take effect on the dates specified in the legislation.

Substantive changes in Medicaid services may occur during the contract year due to Medicaid Program policy or mandated legislative changes. If the Division requires the Plan to provide additional services in the contract year, the Division shall make an adjustment to the capitation rate. Similarly, if the Division requires the Plan to provide fewer services in the contract year, The Division will make an adjustment to the capitation rate.

10.6 Recoupment

If the Plan fraudulently reports, knowingly fails to report, or errs intentionally or unintentionally in reporting information regarding payments, the Division shall request a refund of, or it may recoup from subsequent payments, any payment previously made to the Plan.

The Division may recoup payments made to the Plan when keying errors or system errors affecting correct capitation payments occur. Each recoupment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying Member information and the recoupment amount.

10.7 Third Party Resources

The capitated rates set forth in this Contract have been adjusted to account for the primary liability of third parties to pay such expenses. The Plan shall be responsible for making every reasonable effort to determine the legal liability of third parties, including casualty and other tort liability claims, to pay for services rendered to Members pursuant to this Contract. All funds recovered by the Plan from third party resources shall be treated as income to the Plan.
The Plan may delay payment to a subcontractor or Out-of-Plan Provider for up to sixty (60) days following the date of service in the event that a third party resource is identified from which the subcontractor or Out-of-Plan Provider is obligated to collect payment. If payment is not made by the third party within such sixty (60) day period, the Plan must pay the subcontractor or Out-of-Plan Provider and obtain a refund of any subsequent payments made by the third party. The Plan shall not withhold payment from a subcontractor or Out-of-Plan Provider for services provided to a Member due to the existence of third party resources, because the liability of a third party resource cannot be determined, or because payment shall not be available within sixty (60) days. The Plan shall comply with provisions of 42 C.F.R. 433.139(b)(2) and 42 C.F.R. 433.139(b)(3) in payment of claims for services furnished to certain Medicaid Recipients (e.g., children and pregnant women).

The Plan must report any third party coverage of its Members to DSS within five (5) days of obtaining the information from a source other than DSS.

SECTION 11 - INDEMNIFICATION

11.1 State's Indemnity

In no event shall the State, the Division, or any Recipient be liable for the payment of any debt or fulfillment of any obligation of the Plan or any subcontractor, supplier, Out-of-Plan Provider or any other party, for any reason whatsoever, including the insolvency of the Plan or any of its subcontractors. Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the Plan provided the services directly, (i.e. no balance billing by providers).

The Plan agrees to indemnify, defend, save and hold harmless the Division, its officers, agents, and employees, and each and every Recipient, from all claims, demands, liabilities, suits, judgments, or damages, including court costs and attorney fees, arising out of the performance of this Contract by the Plan, its officers, agents, employees, suppliers, subcontractors or Out-of-Plan Providers, of the covenants and agreements of the Plan set forth herein, including without limitation any claim attributable to:

a. The improper performance of any service, or improper provision of any materials or supplies, irrespective of whether the Division knew or should have known such service, supplies or materials were improper or defective;
b. The erroneous or negligent acts or omissions, including without limitation, disregard of Federal and State Law or regulations, irrespective of whether the Division knew or should have known of such erroneous or negligent acts;
c. The publication, translation, reproduction, delivery, collection, data processing, use, or disposition of any information to which access is obtained pursuant to this Contract in a manner not authorized by this Contract or by Federal and State Law or regulations, irrespective of whether the Division knew or should have known of such publication, translation, reproduction, delivery, collection, data processing, use, or disposition; and
d. Any failure to observe Federal and State Law or regulations, including but not limited to, insurance and labor laws, irrespective of whether the Division knew or should have known of such failure.

The Division shall give the Plan written notice within fifteen (15) days of receipt of any claim or demand made against the Division for which it is entitled to indemnification hereunder (claim); and shall give the Plan an opportunity to appear and defend such claim. Under no circumstances shall the Plan be deemed to have the right to represent the State of North Carolina in any legal matter.

The Plan, its subcontractors, agents, officers, and employees shall act in an independent capacity in the performance of this Contract and not as officers or employees of the Division or of the State of North Carolina. This Contract shall not be construed as a partnership or joint venture between the Plan or any Plan subcontractor and the Division or the State of North Carolina.

SECTION 12 - SUBCONTRACTS

12.1 Requirements

The Plan may enter into subcontracts for the performance of its administrative functions or for the provision of various Covered Services to Members. The Plan must evaluate a prospective subcontractor's ability to perform the activities to be delegated. The Plan shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards. The Plan shall identify deficiencies or areas for improvement in the subcontractor's performance and require the subcontractor to take corrective action.

Each subcontract, and any amendment to a subcontract, shall be in writing and approved in writing by the Division. All subcontracts must fulfill the requirements of 42 C.F.R. 438.6 and 42 C.F.R. 434.6 that are appropriate to the service or activity delegated under the subcontract. The subcontract must specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

All subcontractors must be eligible for participation in the Medicaid program and are bound to all the terms of this Contract and applicable Federal and State laws and regulations. No subcontract shall in any way relieve the Plan of any responsibility for the performance of its duties pursuant to this Contract. The Plan shall notify the Division in writing of the termination of any approved subcontract within ten (10) days following termination. All subcontracts must clearly identify the functions that are subcontracted and provide the Division upon request with results from any audits or reviews of subcontractors. All subcontracts shall:

a. Identify the population covered by the subcontract;
b. Specify the amount, duration and scope of services to be provided by the subcontractor;
c. Specify procedures and criteria for extension, re-negotiation and termination;
d. Make full disclosure of the method and amount of compensation or other consideration to be received from the Plan;
e. Provide for monitoring by the Plan of the quality of services rendered to Members;
f. All subcontracts shall contain a provision that the Plan monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards;
g. All subcontracts shall contain a provision that upon the Plan's identification of deficiencies or areas for improvement in the subcontractor's performance, the subcontractor must take corrective action;
h. Contain no provision which provides incentives, monetary or otherwise, for the withholding from Members of medically necessary services;
i. Contain a prohibition on assignment or any further subcontracting without the prior written consent of the Division; and
j. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the subcontract, including without limitation, the obligation to comply with all applicable Federal and State laws and regulations, all rules, policies and procedures of the Department and Division, and all standards governing the provision of Covered Services and information to Members; all quality assurance requirements; all record keeping and reporting requirements; the obligation to maintain the confidentiality of information; all rights of the Division and other officials to inspect, monitor and audit operations; the rights of the Division and other State/Federal officials to inspect and audit any financial records; all indemnification and insurance.

12.2 Timeliness of Provider Payments

Payments to providers by the Plan must be made on timely basis, consistent with claims payment procedures described in 1902(a)(37)(A) of the Social Security Act and 42 C.F.R**.** 447.45. The Plan must ensure that ninety percent (90%) of all claims for covered services, for which no further written information or substantiation is required in order to make payment, are paid within thirty (30) days of the date of receipt; and that ninety nine percent (99%) of such claims are paid within ninety (90) days of the date of receipt. Date of receipt is the date the Plan receives the claim, as indicated by its date stamp on the claim. The date paid is the date if the check or other form of payment. If a plan is out of compliance for any month(s) in the their quarterly report, they shall be penalized one percent (1%) for each month. This penalty shall be applied to the capitation payment made to the HMO in the month following the submission of the quarterly report. Therefore, if the HMO is out of compliance for all three (3) months in the quarterly report, a penalty of three percent (3%) is applied to the capitation payment made in the month following the submission of the quarterly report.

The Plan shall be assessed an additional one percent (1%) non-refundable penalty for submitting data after the report due date. This penalty shall accrue monthly until the Division receives the data. This penalty is in addition to the penalty described above. One hundred percent (100%) of the Plan's monthly capitation payment due shall be subject to each of the penalties listed. The Financial Operations Section, in conjunction with the Managed Care Section of the Division, shall communicate the penalties in writing to the HMOs and the Division's fiscal agent. The Plan is required to submit a written explanation with each over-aged claim or group of over-aged claims that do not comply with the CMS ninety percent (90%) and ninety-nine percent (99%) goals, respectively.

MCOs that fail to submit data timely are subject to the withhold penalty noted in Section 9.3 of this contract as well as the penalties described within this Section and Section 14.

12.3 Remedies

The Division shall have the right to invoke against any subcontractor, any remedy set forth in this Contract, including the right to require the termination of any subcontract, for each and every reason for which it may invoke such a remedy against the Plan or require the termination of this contract**.**

SECTION 13 - DEFAULT AND TERMINATION

13.1 Severability

In the event that any provision of this Contract (including items incorporated by reference) is found to be unlawful or unenforceable, then both the Department and the Plan shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, then this Contract shall continue in full force and effect, and all remaining provisions shall be binding upon each party of this Contract. If the laws and regulations governing this Contract should be amended or judicially interpreted so as to render the fulfillment of this Contract impossible or economically infeasible, as determined jointly by the Division and the Plan, then both the Division and the Plan shall be discharged from any further obligations created under the terms of this Contract.

13.2 Plan Breach, Remedies

If the Plan fails to fulfill its duties and obligations pursuant to this Contract, the Division may issue a written notice to the Plan indicating the violation(s) and requiring the submission of a corrective action plan, within thirty (30) days, that is subject to the approval of the Division; or depending upon the nature of the deficiency, the Division shall be entitled to exercise any other right or remedy available to it, whether or not it issues a deficiency notice or provides the Plan with the opportunity to take corrective action with thirty (30) days notice. The Plan may request an extension of the thirty (30) day requirement if Good Cause can be shown to the Division Director. Failure to correct the violation(s), to the satisfaction of the Division may lead to the imposition of all or some of the sanctions listed below:

a. Suspension of further enrollment for a defined time period;
b. Suspension, recoupment, withholds of the monthly capitation payments or assessment of non-refundable or refundable penalties;
c. Termination of this Contract.

13.3 Option to Terminate

This Contract may be terminated without cause by either party upon sixty (60) days prior written notice to the other party. Termination shall be effective only at midnight of the last day of a calendar month. The option of the Plan to terminate this Contract prior to the end of the initial term or any renewal term shall be contingent upon the payment of liquidated damages pursuant to Section 13.6, performance of all obligations upon termination, pursuant to Section 13.5, and payment in full of any refunds or other sums due the Division pursuant to this Contract.

The Division has the authority to terminate the contract and provide enrollees their Medicaid benefits through other options included in the State plan, if the Division determines that the Plan has failed to do either of the following:

a. Carry out the substantive terms of its contract; or
b. Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

13.4 Grounds for Immediate Termination

The Division shall have the right to immediately terminate this Contract upon the occurrence of any of the following events:

a. The Plan, its subcontractors or suppliers violate or fail to comply with any applicable provision of Federal and State or regulations;
b. The conduct of the Plan, any subcontractor or supplier, or the standard of services provided by or on behalf of the Plan threatens to place the health or safety of any Member in jeopardy;
c. The Plan becomes subject to exclusion from participation in the Medicaid program pursuant to Section 1902(p)(2) of the Act (42 U.S.C. 1396a(p));
d. The Plan or any subcontractor provides fraudulent, misleading, or misrepresented information to any Member;
e. Gratuities of any kind were offered to or received by any public official, employee or agent of the State from the Plan, its agents, employees, subcontractors or suppliers, in violation of Section 1.4;
f. Either of the sources of reimbursement for Medical Assistance, appropriations from the General Assembly of the State or from the Congress of the United States, no longer exists, or in the event that the sum of all obligations of the Division incurred pursuant to this Contract and all other Contracts entered into by the Division, including without limitation, all Statements of Participation entered into pursuant to the State Plan, equals or exceeds the balance of such sources available to the Division for "Medical Assistance Benefits" for the contract year in which this Contract is effective, less One Hundred Dollars ($ 100.00), then this Contract shall immediately terminate without further obligations of the Division as of that moment.

Certification by the Director if the Division of the occurrence of any of the events stated above shall be conclusive. The Division shall attempt to provide the Plan with ten (10) days notice of the possible occurrence of events described in Subsection f of this Section.

13.5 Obligations Upon Termination

Upon termination of this Contract, the Plan shall be solely responsible for the provision and payment for all Covered Services for all Members for the remainder of any month for which the Division has paid the monthly capitation rate. Upon final notice of termination, on the date, and to the extent specified in the notice of termination, the Plan shall:

a. Continue providing Covered Services to all Members until midnight on the last day of the calendar month for which a capitated rate payment has been made by the Division;
b. Continue providing all Covered Services to all infants of female Members who have not been discharged from the hospital following birth, until each infant is discharged;
c. Continue providing inpatient Hospital Services and any services directly related to inpatient care, to any Members who are hospitalized on the termination date, until each Member is discharged;
d. Arrange for the transfer of patients and medical records to other appropriate providers;
e. Promptly supply to the Division information on all outstanding claims and arrange for the payment of such claims within the time periods provided herein;

f. Take such action as may be necessary, or as the Division may direct, for the protection of property related to this Contract, which is in the possession of the contractor and in which the Division has or may acquire an interest;
g. Provide for the maintenance of all records for audit and inspection by the Division, CMS and other authorized government officials, in accordance with Section 8; the transfer of all data, including encounter data and records to the Division or its agents as may be requested by the Division; and the preparation and delivery of any reports, forms or other documents to the Division as may be required pursuant to this Contract or any applicable policies and procedures of the Division; and
h. Notify Members of contract termination in writing within forty five (45) days prior to the termination date. The notification letter must be approved by the Division.

The covenants set forth in this Section shall survive the termination of this Contract and shall remain fully enforceable by the Division against the Plan. In the event that the Plan fails to fulfill each covenant set forth in this Section, the Division shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such covenants, all at the sole cost and expense of the Plan and the Plan shall refund to the Division all sums expended by the Division in so doing.

13.6 Liquidated Damages

The Plan acknowledges and agrees that the Division has incurred substantial expense in connection with the preparation and entry into this Contract, including expenses relating to training of staff, data collection and processing, actuarial determination of capitated rates for the initial term and each renewal term, and ongoing changes to the Medicaid Management Information System (MMIS). The Plan further acknowledges and agrees that in the event this Contract is terminated prior to the end of the initial term or any renewal term, due to the actions of the Plan or due to the Plan's failure to fully comply with the terms and conditions of this Contract, the Division shall incur substantial additional expense in processing the disenrollment of all Members and mass MMIS changes, in effecting additional staffing changes, in procuring alternative health care arrangements for Members and in modifying any Member service materials identifying the Plan; and that such expense is difficult or impossible of accurate estimation.

Based upon the foregoing, the Plan and the Division have agreed to provide for the payment by the Plan to the Division of liquidated damages equal to ten thousand ($ 10,000) plus one percent (1%) of the maximum monthly capitation payment for each month of the Contract term remaining after the effective date of termination, such payment to be made no later than thirty (30) days following the date of termination. The Division and the Plan agree that the sum set forth herein as liquidated damages is a reasonable pre-estimate of the probable loss which shall be incurred by the Division in the event this Contract is terminated prior to the end of the Contract term or any renewal term.

SECTION 14 – PENALTIES

14.1 Plan Penalties

If the Plan does not adhere to reporting requirements and deadlines stipulated within this contract, the Division of Medical Assistance may impose penalties on a Plan until the Plan complies with the reporting requirement(s). A penalty or penalties shall be imposed by reducing the monthly premium payment(s) to the Plan. One hundred percent (100%) of the Plan’s monthly capitation payment due shall be subject to each of the penalties listed. In subsequent financial data reports, all penalties must be reflected that have been imposed by either the terms or conditions of this contract, Division policy, applicable law, or regulation. Non-compliance with data reporting requirements stipulated in this contract is grounds for contract termination.

The Financial Operations Section in conjunction with the Managed Care Section of the Division shall communicate the penalties in writing to the Plan and the Division's fiscal agent.

14.2 Penalties Associated with Financial Reporting

If the Financial Operations Section of the Division does not receive a Plan's financial data reports detailed in Appendix V by the stipulated date, that Plan shall incur a penalty of five hundred dollars ($500) per day until the Financial Operations Section receives the report. This penalty shall be applied to the capitation payment made to the HMO in the month following the submission of the quarterly report.

14.3 Penalties Associated with Program Reporting

As stipulated in Section 9.3 and Section 12.2, if a plan is out of compliance for any month(s) in the their Timeliness of Provider Payments quarterly report, they shall be penalized one percent (1%) for each month. This penalty shall be applied to the capitation payment made to the HMO in the month following the submission of the quarterly report. Therefore if the HMO is out of compliance for all three (3) months in the quarterly report, a penalty of three percent (3%) is applied to the capitation payment made in the month following the submission of the quarterly report.

The Plan shall be assessed an additional one percent (1%) non-refundable penalty for submitting data after the report due date (per Section 12.2). This penalty shall accrue monthly until the Division receives the data. This penalty is in addition to the penalty described above. One hundred percent (100%) of the Plan's monthly capitation payment due shall be subject to each of the penalties listed.

14.4 Plan Sanctions

Intermediate sanctions as specified in 42 C.F.R. 438.702 may be imposed when the Division determines that the Plan acts or fails to act as follows:

a. Fails substantially to provide medically necessary services that the Plan is required to provide, under law or under its contract with the Division, to an enrollee covered under the contract;
b. Imposes on enrollees' premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
c. Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a recipient, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by Recipients whose medical condition or history indicates probable need for substantial future medical services;
d. Misrepresents or falsifies information that it furnishes to CMS or to the Division;
e. Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;
f. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. 422.208 and 42 C.F.R. 422.210 of this Chapter;
g. The Division determines the Plan has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Division or that contain false or materially misleading information;
h. The Plan has violated any of the other requirements of sections 1903(m) or 1932 of the Act, and any implementing regulations.

For any of the violations under paragraphs 42 C.F.R. 438.700(d)(1) and (d)(2) of this section, only the sanctions specified in 42 C.F.R. 438.702, paragraphs (a)(3), (a)(4), and (a)(5) may be imposed. The Division may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

14.5 Intermediate Sanctions

The types of intermediate sanctions that the Division may impose include the following:

a. Civil money penalties in the amounts specified in 42 C.F.R. 438.704;
b. Appointment of temporary management as provided in 42 C.F.R. 438.706;
c. Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
d. Suspension of all new enrollment, including default enrollment, after the effective date of the sanction;
e. Suspension of payment for Recipients enrolled after the effective date of the sanction and until CMS or the Division is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

The Division shall retain authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 C.F.R. 438.700, as well as additional areas of noncompliance.

The limit on, or the maximum civil money penalty the Division may impose varies depending on the nature of the Plan's action or failure to act.

The limit is $25,000 for each of the following determinations:

a. Failure to provide services;
b. Misrepresentation or false statements to enrollees, potential enrollees, or health care providers;
c. Failure to comply with physician incentive plan requirements;
d. Marketing violations.

The limit is $100,000 for each determination of:

a. Acts of discrimination among enrollees on the basis of their health status or need for health care services;
b. Misrepresentation or false statements to CMS or the Division.

The limit is $15,000 for each recipient the Division determines was not enrolled because of a discriminatory practice as stated in 42 C.F.R. 438.700(b)(3). This is subject to the overall limit of $100,000 stated above.

For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater. The Division must deduct from the penalty the amount of overcharge and return it to the affected enrollees.

14.6 Temporary Management Sanction

The Division must impose temporary management (regardless of any other sanction that may be imposed) if it finds that a Plan has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act. The Division must also grant enrollees the right to terminate enrollment without cause, as described in 42 C.F.R. 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment.

The Division may not delay imposition of temporary management to provide a hearing before imposing this sanction. The Division may not terminate temporary management until it determines that the Plan can ensure that the sanctioned behavior will not recur.

SECTION 15 - PHYSICIAN INCENTIVE PLAN

15.1 Operation of a Physician Incentive Plan

The Plan may operate a Physician Incentive Plan (PIP) only if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual. The PIP shall comply with 42 C.F.R. 438.6(h), 42 C.F.R. 422.208 and 422.210. The Plan must provide the information on its physician incentive plans to any Medicaid client, upon request. Enrollment materials or the handbook should annually disclose to enrollees their right to adequate and timely information related to physician incentives. A Plan that has physician incentive plans placing a physician or physician group at substantial financial risk for the cost of services the physician or physician group does not furnish must provide adequate stop-loss protection to the individual physicians and conduct enrollee surveys**.**

15.2 Disclosure

The Plan must report adequate information specified in the PIP regulations to the Division in order that the Division may adequately monitor the Plan. The disclosure must contain the following information in sufficient detail to enable the Division to determine whether the incentive plan complies with PIP requirements:

a. Whether services not furnished by the physician or physician group is covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made;
b. The type of incentive arrangement; for example, withhold, bonus, capitation;
c. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus;
d. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection;
e. The panel size and, if patients are pooled, the approved method used. In the case of capitated physicians or physician groups, capitation payments paid to primary care physicians for the most recent year broken down by the percent for primary care services, referral services to specialists, and hospital and other types of provider (e.g., nursing home and home health agency) services;
f. In the case of those prepaid plans that are required to conduct recipient surveys, the survey results (which must be provided in a timely manner to Medicaid Recipients upon request).

SECTION 16 - FQHC ACCESS

The Plan must pay FQHCs and Rural Health Centers (RHCs) rates not less than those paid to other providers for comparable services. The Plan cannot pay the annual cost-settlement.

SECTION 17 - ENTIRE AGREEMENT

This Contract, Attachment(s), Amendments, Appendices, and the Application Form represent the entire agreement between the Plan and the Division with respect to the subject matter stated herein and supersedes all other contracts and agreements between the parties. No modification or change to any provision of this Contract shall be effective unless it is in writing and signed by a duly authorized representative of the Plan and the Division, and without the prior approval of CMS, provided however that this Contract shall be amended whenever and to the extent required by changes in Federal and State or regulations or Division policy.

IN WITNESS WHEREOF, the parties have caused this Contract to be executed by their duly authorized representatives.

Corporate Seal

State of North Carolina Division of Medical Assistance Managed Care Section	_____ Health Maintenance Organization
_____ Program Administrator Date	_____ President Date
_____ Gary Fuquay, Director Date	_____ Corporate Secretary Date

APPENDIX I

DEFINITION OF TERMS

1.1 Action - The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the Plan to act within the timeframes provided in 42 C.F.R. 438.408(b); or for a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 C.F.R. 438.52(b)(2)(ii), to obtain services outside the network.

1.2 ANSI – American National Standards Institute

1.3 Appeal - a request for review of an action, as "action" is defined in this Appendix in 1.1 above.

1.4 Applicant - Any person who has signed an application for enrollment in an HMO and whose enrollment certification is pending.

1.5 Attending Physician - The participating or referral physician in whose immediate care a Member may be for a particular illness, injury or condition.

1.6 Capitation Rate - The amount to be advanced monthly to a Plan for each Member enrolled in the Plan's Health Benefit Plan based on the Member's aid category, age, and gender.

1.7 Case Management - Services providing assistance in gaining access to and coordination of needed social, educational, and other medically necessary services regardless of the source of the funding for the needed service.

1.8 Manager - Registered Nurse, preferably with previous experience case managing members who have special health care needs. Certification is recommended.

1.9 C.F.R. – Code of Federal Regulations

1.10 Children with Special Health Care Needs – For the purposes of this contract includes these five subsets:

1. Blind/Disabled Children (eligible for SSI under title XVI);
2. In foster care or other out-of-home placement;
3. Receiving foster care or adoption assistance;
4. Self-identified through the Medicaid eligibility process;
5. Receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of title V as defined by the State in terms of either program participant or special health care needs.

Children in categories 1 through 4 will be identified to the Plan on the monthly enrollment reports.

1.11 **C**MS - Centers for Medicare and Medicaid Services

1.12 Consumer Assessment Health Plan Survey (CAHPS) - A NCQA/CMS patient satisfaction survey tool that addresses a wide variety of issues including access to services, quality measures, and satisfaction. There is a version of the survey tool that is specific to Medicaid and to adults and children. All sampling and survey methodology is to comply with NCQA standards.

1.13 Contract Term - The initial term of this Contract or any renewal term.

1.14 Covered Services - The services identified in Appendix III, which the Plan agrees to provide to all Members pursuant to the terms of this Contract.

1.15 DHHS - United States Department of Health and Human Services

1.16 Days - Except as otherwise noted, refers to calendar days. "Working day" or "business day" means day on which the Division is officially open to conduct its affairs.

1.17 Days of Enrollment – The first day of the month.

1.18 Days from Enrollment – Enrollment is the first day of the month.

1.19 Disenrollment - Action taken by the Division to remove a Member's name from the monthly Enrollment Report following a Division's receipt and approval of a request for disenrollment or a determination that the Member is no longer eligible for enrollment in the Plan.

1.20 Division - The State of North Carolina, Division of Medical Assistance

1.21 DSS - Department of Social Services

1.22 Eligible Recipient - Recipients who are eligible to elect HMO coverage.

1.23 Emergency Medical Condition –
(A) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
(2) serious impairment to bodily functions, or
(3) serious dysfunction of any bodily organ or part; or

(B) With respect to a pregnant woman who is having contractions:

(1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
(2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

1.24 Emergency Medical Services - with respect to an individual enrolled with an organization, covered inpatient and outpatient services that:
(A) are furnished by a provider that is qualified to furnish such services; and,
(B) are needed to evaluate or stabilize an emergency medical condition as defined above.

1.25 Encounter Data - A record of a medically related service or visit rendered by a provider to a Member who is enrolled in the Plan during the date of service. It includes all services for which the Plan incurred any financial responsibility; in addition, it may include claims for reimbursement, which were denied by the Plan.

1.26 Enrollees - The entire membership in the Plan, including all of the Members and all persons, other than recipients, who are enrolled in the Plan.

1.27 Enrollment - Action taken by the Division to add a Member's name to the monthly Enrollment Report following the receipt and approval by the Division of an enrollment application from an eligible Recipient.

1.28 Enrollment Period - The time span during which a recipient is enrolled with a Plan.

1.29 Expanded Services - Services included in Covered Services, which are in addition to the minimum coverage required by the Division and which the Plan agrees to provide throughout the term of this Contract in accordance with the standards and requirements set forth in this Contract.

1.30 Facility - Any premises (a) owned, leased, used or operated directly or indirectly by or for the Plan or its affiliates for purposes related to this Contract; or (b) maintained by a sub-contractor to provide services on behalf of the Plan.

1.31 Fee-for-Service - A method of making payment directly to health care providers enrolled in the Medicaid program for the provision of health care services to Recipients based on the payment methods set forth in the State Plan and the applicable policies and procedures of the Division.

1.32 Fiscal Agent - An agency that processes and audits Medicaid provider claims for payment and performs certain other related functions as an agent of the Division.

1.33 FQHC - Federally Qualified Health Center

1.34 FTE - Full time equivalent, based on forty (40) hours worked per week.

1.35 Grievance - an expression of dissatisfaction about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the Plan level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights).

1.36 Grievance Procedure - The written procedures pursuant to which Members may express dissatisfaction with the provision of services by the Plan and the methods for resolution of Member complaints by the Plan.

1.37 Health Assessment - The systematic collection of subjective and objective information used to determine the client's health status and need for medical care in relation to developmental, physiological, preventive, and psychological life processes.

1.38 Health Benefits Manager - Third party contractor who enrollees recipients in a Plan

1.39 Health Check - A child health program for recipients from birth through the age of twenty (20) designed to improve the availability and accessibility of preventive and primary health care services. It is sponsored by the Division.

1.40 Hearing - A formal proceeding before an Office of Administrative Hearing Law Judge in which parties affected by an action or an intended action of the Division shall be allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.

1.41 HEDIS - Health Plan Employer Data and Information Set (HEDIS) is a set of standardized performance measures designed to reliably compare the performance of managed health care plans.

1.42 IDEA - Individuals with Disabilities Education Act (IDEA) - Federal law (PL 99-457) which requires special services for children with special needs from birth to age twenty one (21) years.

1.43 Insolvency - The inability of the Plan to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (i) any capital and surplus required by law for its organization; or (ii) the total par or stated value of its authorized and issued capital stock. "Liabilities" shall include, but not be limited to, reserve required by the Department of Insurance pursuant Chapter 58 Articles 67 of the North Carolina General Statutes (locate specific reference).

1.44 Marketing - Any activity conducted by or on behalf of the Plan, in which information regarding the services offered by the Plan is disseminated in order to encourage eligible Recipients to enroll in the Plan.

1.45 Medicaid Identification (MID) Card - The Medical Assistance Eligibility Certification card issued monthly by the Division to Recipients.

1.46 Medicaid for Infants and Children (MIC) - A program for medical assistance for children under the age of nineteen (19) whose countable income falls under a specific percentage of the Federal Poverty Limit and who are not already eligible for Medicaid in another category.

1.47 Medicaid for Pregnant Women (MPW) - A program for medical assistance for pregnant women whose income falls under a specified percentage of the Federal Poverty Limit and who are not already eligible in another category.

1.48 Medical Assistance (Medicaid) Program - The Division's program to provide medical assistance to eligible citizens of the State of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. se.

1.49 Medical Record - A single complete record, which documents all of the treatment, plans developed for and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by Plan Providers or Out-of-Plan Providers.

1.50 Medically Necessary Services - Those services which are in the opinion of the treating physician, reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time the services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration, or scope of coverage may not arbitrarily be denied or reduced solely because of the diagnosis, type of illness, or condition (42 C.F.R. 440.230). Medicaid EPSDT coverage rules (42 U.S.C. 1396(r)(5) and 42 U.S.C. 1396d (a)).

1.51 Member - An eligible Recipient who is enrolled in the Plan.

1.52 NSF - National Standard Format

1.53 Out-of-Plan Services - Health care services, which the Plan is not required to provide under the terms of this Contract. The services are Medicaid covered services reimbursed on a fee-for-service basis.

1.54 Out-of-Network Provider - Any person or entity providing services who is not directly employed by or through the Plan or any of its subcontractors.

1.55 Plan - An HMO licensed by the NC Department of Insurance, which has signed a Contract with the Division to provide and manage the health care needs of enrolled Members on a prepaid basis.

1.56 Plan Benefits - The prepaid health care benefits offered by the Plan for the provision of Covered Services pursuant to this Contract.

1.57 Plan Provider - Any person or entity providing Covered Services on behalf of the Plan that is directly employed by or through the Plan or any of its subcontractors

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1.58 Potential enrollee – A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO. (438.10 (a) page 11 of checklist)

1.59 Primary Care Provider (PCP) - A licensed medical practitioner responsible for supervising, coordinating and providing initial and primary care to a Member, for initiating referrals for specialist care, and for maintaining the continuity of patient care; a General Medical Practitioner, an Internist, a Pediatrician, an Obstetrician/Gynecologist, a Family Practitioner, a Physician's Assistant, or a Family Nurse Practitioner. For children with special health care needs, a specialist may perform as a Primary Care Physician.

1.60 Prior Authorization - The act of authorizing specific services before they are rendered.

1.61 Provider - Any person or entity approved by the Division, which renders health care services to Recipients.

1.62 QARI - Also referred to as a health care quality improvement system for states; a framework for a health care quality improvement system for Medicaid managed care; recommends evaluation procedures to be used by states to evaluate a Plan's internal quality improvement system.

1.63 Quality Assurance/Quality Improvement - The process of assuring that health care services provided to Members are appropriate, timely, accessible, available and medically necessary.

1.64 Recipient - Any person certified by the Division as eligible to receive services and benefits under the North Carolina Medicaid Program.

1.65 Reconsideration Review - An informal session before a Division Hearing Officer wherein a Member or the Plan, affected by an action or an intended action by the Division and the Managed Care Director shall be allowed to present and discuss information as to why such action should or should not be taken, and described more specifically in NCAC T10: 26I (for Members) and NCAC T10: 26K (for the Plan). The decision of the Hearing Officer is subject to appeal through the Office of Administrative Hearings (OAH).

1.66 Reinsurance - Insurance purchased by a Plan from insurance companies to protect against part of the costs of providing Covered Services to Members.

1.67 Reopened (Administratively) WFFA Case - A terminated Work First case may be administratively reopened with no loss of coverage if certain eligibility criteria are met within specified time frames.

1.68 Risk - A significant chance of loss assumed by the Plan which arises if cost of providing Covered Services to Members exceeds the capitation rate paid by the Division to the Plan.

1.69 Service Area - Any defined geographic area within which the Plan and the Division have agreed to make Covered Services available and readily accessible to the Members.

1.70 Service Location - Any location at which a Member may obtain any Covered Services from a Plan Provider.

1.71 State - State of North Carolina

1.72 State Plan - The "State Plan" submitted under Title XIX of the Social Security Act, Medical Assistance Program for the State of North Carolina and approved by CMS.

1.73 Subcontract - An agreement approved in writing by the Division, which is entered into by the Plan in accordance with Section 12.

1.74 Subcontractor - Any person or entity which has entered into a subcontract with the Plan.

1.75 Third Party Resource - Any resource available to a Member for payment of expenses associated with the provision of Covered Services, other than those which are exempt under Title XIX of the Act, including but not limited to, insurers, tortfeasors, and worker’s compensation plans.

1.76 Urgent Conditions - A medical condition that warrants medical attention and intervention within 12-24 hours. If medical care is not rendered, the "urgent" condition could seriously compromise the patient's condition and outcome for a full recovery.

1.77 WFFA - Work First for Family Assistance

APPENDIX II

ELIGIBILITY GROUPS

Enrollment in Mecklenburg County
for the Month of July 2002

Category	**Enrollment**
Work First for Family Assistance ..... (WFFA)	5,297
Family and Children's Medicaid without Medicaid deductible (MAF).....	6,527
Medicaid for Infants and Children (MIC)	6,266
Foster Care Children (HSF and IAS)..... [with SSI]	0
Medicaid for Pregnant Women (MPW).....	366
Medicaid for the Disabled (MAD) …….	1,364
Medicaid for the Blind (MAB)	13
Medicaid for Adult Care Home Residents (SAD)	39
Medicaid Special Assistance for the Blind (MSB) ...	0

Appendix III
Schedule of Benefits
In-Plan Benefits

- Adult Preventive Medicine Services
- Ambulance
- Chiropractic Services
- Clinic Services - Except for Mental Health and Substance Abuse
- Diagnostic Services
- Dialysis
- Durable Medical Equipment
- Emergency Room
- EPSDT/Health Check
- Eye Care
- Family Planning Services & Supplies
- Hearing Aids
- Home Health
- Home Infusion Therapy
- Hospice
- Inpatient Hospital - Except for Mental Health and Substance Abuse
- Laboratory Services
- Midwife
- Occupational Therapy
- Optical Supplies
- Outpatient Hospital
- Physical Therapy
- Physician Services, including Physician Assistants and Family Nurse Practitioners – Except for Mental Health and Substance Abuse
- Podiatry
- Postpartum Newborn Home Visit –EPSDT
- Postpartum Newborn Home Visit – Maternal Assessment
- Postpartum Newborn Home Visit – Newborn Assessment
- Private Duty Nursing
- Prosthetics/Orthotics
- Radiology Services
- Speech Therapy
- Sterilization
- Total Parenteral Nutrition

Out-of-Plan Benefits

- CAP Services
- At-Risk Case Management
- Child Service Coordination
- Dental
- D.S.S. Non-Emergency Transportation
- Developmental Evaluation Center Services
- HIV Case Management
- ICF/MR
- Maternity Care Coordination
- Mental Health and Substance Abuse
- Mental Health - Inpatient & Outpatient
- Personal Care Services
- Prescription Drugs
- School-Related and Head Start Therapies
- Skilled or Intermediate Nursing Care

APPENDIX IV

SCOPE OF HEALTH CHECK/EPSDT SERVICES

Section 1905(r) of Social Security Act sets forth the basic requirements for the program.

Under the EPSDT benefit, the Plan must provide screenings, including vision and hearing, and services at intervals, which meet reasonable standards of medical practice, established after consultation with recognized medical organizations involved in child health care. The Plan must also provide for medically necessary screening, vision and hearing services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service, which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical illness, or a condition identified by a screen, must be provided to EPSDT participants.

Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration and scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

APPENDIX V

STATISTICAL REPORTING REQUIREMENTS

With further direction and instructions from the Division, the Plan will be required to submit data and measurements on an annual (unless otherwise indicated) basis for quality of care and service measures and performance improvement projects as defined in Appendix IX for Medicaid members. Other quality measures may be phased in during consecutive contract years at the discretion of the Division. The Plan will be provided with the necessary information and forms to be used in meeting the statistical and other reporting requirements of this contract. Described below are the reports that each Plan is required to complete and send to NC DMA by June 30 of each calendar year. The period of time reported upon will be January 1 through December 31 of the preceding calendar year. Each Plan will utilize the HEDIS Technical Specifications (for the particular reporting year) to fulfill the statistical reporting requirements for the quality measures. The Plan will execute all applicable HEDIS Technical Specifications as they pertain to the Medicaid population of the Plan including, continuous enrollment, allowable gaps, etc. At the Plan's expense, submitted data must be audited for completeness and accuracy by a NCQA accredited auditor. An explanation of how the data was calculated is also required in the yearly report. Questions regarding reporting requirements may be addressed through quarterly HMO Quality Management or Data Advisory Committee Meetings. For the purpose of clarification, when "member" is written, the reference is to all or specified Medicaid members.

EFFECTIVENESS OF CARE:
HEDIS MEASURES

CHILDHOOD IMMUNIZATIONS**
ADOLESCENT IMMUNIZATIONS**
BREAST CANCER SCREENING
CERVICAL CANCER SCREENING

DMA MEASURE

LEAD SCREENINGS**
Proportion of Medicaid children ages 12 and 24 months who had blood lead screenings within the measurement year.

DIABETES CARE FOR CSHCN (hybrid HEDIS measure) -Report the number and percentage of CSHCN with diabetes ages 0 through 18 in the Plan with diabetes who had the following tests performed during the measurement year: Hemoglobin A_1C and Urine for Microalbuminuria.) Report each test individually and both tests combined.

DIABETES CARE FOR ADULTS (hybrid HEDIS measure)-Report number and percentage of diabetic adults ages 21-64 who had the following performed during the measurement year: Hemoglobin A_1C, LDL-C, and dilated eye exam. Report each test individually and all tests combined.

ACCESS/AVAILABILITY OF CARE:
HEDIS MEASURES

CHILDREN'S ACCESS TO PCP**
PRENATAL AND POSTPARTUM CARE
ADULT'S ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES
AVAILABILITY OF LANGUAGE INTERPRETER SERVICES

DMA MEASURES

CHILDREN'S ACCESS TO THERAPY SERVICES**-Report number and percentage of children, birth through age 18 who received speech, physical, or occupational therapy during the measurement year.

NEW MEMBER HEALTH ASSESSMENT (Non-pregnant) ** Refer to "New HMO Member Health Assessment Policy and Procedure" from 2/23/00 Quarterly QM Meeting*
The Plan must ensure that newly enrolled Medicaid members who either had no previously established relationship with a provider/practice or chose a new provider/practice have a face to face health assessment with a provider within the first ninety (90) calendar days of enrollment with the Plan. Report the total number of members who met these criteria and of those who met the criteria report the percentage who had an actual face to face encounter with a provider within the first ninety (90) calendar days of enrollment. Also from the total number of members who met the above criteria report the percentage of newly enrolled Medicaid members that Plan was unable to contact.

NEW MEMBER HEALTH ASSESSMENT (Pregnant Female)
For Members identified as being pregnant and not having an established relationship with an OB provider, the Plan should request the Member select an OB provider and assist the Member in scheduling an initial prenatal health assessment encounter within fifteen (15) business days of enrollment. For pregnant Members already established with an OB provider, the Plan should verify via telephone or mail that the Member is indeed receiving prenatal care with the indicated provider. The Plan shall document its efforts to contact each new Member within the first forty-five (45) calendar days of enrollment to schedule the health assessment.

Report the total number of members who met these criteria and of those who met the criteria report the percentage who had an actual face to face encounter with a provider within the first fifteen (15) days of enrollment. Also from the total number of members who met the above criteria report the percentage of newly enrolled Medicaid members that Plan was unable to contact.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) ASSESSMENT
The Plan must ensure that new members identified on the monthly enrollment tape as children with special health care needs receive a needs assessment for case management within thirty (30) calendar days of enrollment and assigned to a case manager, if appropriate, within five (5) business days of assessment. The Plan must make, in lieu of completing the needs assessment, at least three (3) documented attempts to perform the needs assessment within forty five (45) calendar days of enrollment. As an annual summary, report the total number and percentage of CSHCN children identified on the monthly enrollment reports; the number and percentage of total CSHCN enrollment who received a needs assessment within thirty (30) calendar days, the number and percentage of total CSHCN enrollment in which three (3) or more attempts for assessment were completed within forty five (45) days, and the total number and percentage of the total CSHCN receiving case management assignments.

AFTER HOURS SURVEY
Provide annual report of monitoring 24-hour accessibility through random calls to PCPs during and after regular office hours. Provide description of corrective actions taken when providers are found to be non-compliant.

APPOINTMENT AVAILABILITY/ACCESSIBILITY SURVEY
Provide annual report of monitoring for appointment availability/accessibility standards as outlined in **Appendix XV** of this contract.

USE OF SERVICES:
HEDIS MEASURES
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE
WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEAR OF LIFE

INPATIENT UTILIZATION- GENERAL HOSPITAL/ACUTE CARE**
AMBULATORY CARE**

DMA MEASURES

REFERRAL DENIALS**
Proportion of referrals for services denied categorized by reason as specified by the Plan utilization protocols.

NON-AUTHORIZED VISITS
Proportion of visits for services (ER, Consulting Specialists, Ancillary) obtained but not authorized by the Plan.

HEALTH CHECK SCREENINGS**
Proportion of Medicaid children (in age appropriate categories and according to the State's periodicity schedule) continuously enrolled for 12 months with the health Plan, who were eligible for and received at least one Health Check screening during the measurement year.

ABORTIONS
The Plan shall report the number of therapeutic abortions performed on Medicaid members that have been paid for by the Plan during each calendar quarter. The number of abortions shall be separated out by the reason that the abortion was performed. The acceptable reasons are listed in Section 6.27 of this contract. Reports must be submitted to the Division no later than forty five (45) calendar days after the end of the calendar quarter.

HYSTERECTOMIES
The Plan shall report the number of hysterectomies performed on Medicaid members that have been paid for by the Plan during each calendar quarter. Reports must be submitted to the Division no later than forty five (45) calendar days after the end of the calendar quarter.

STERILIZATIONS
The Plan shall report the number of sterilizations performed on Medicaid members that have been paid for by the Plan during each calendar quarter. Reports must be submitted to the Division no later than forty five (45) calendar days after the end of the calendar quarter.

HEALTH PLAN STABILITY:
HEDIS MEASURE

PRACTITIONER TURNOVER

SATISFACTION:
HEDIS/CAHPS

MEDICAID MEMBER SATISFACTION SURVEY**
Adult and Child

DMA MEASURES

PROVIDER SATISFACTION SURVEY
Using self-determined methods, the Plan will administer an annual Provider Satisfaction Survey and provide the results to the State Agency.

COMPLAINTS AND GRIEVANCES/APPEALS**
The Plan shall report all member complaints, grievances and appeals and a subset of the number of expedited appeals. The report shall contain the number of covered members, total number of

grievances/complaints categorized by reason for grievance, the number of grievances referred to the second level review, and the number of grievances resolved at each level, total time of resolution, and their outcome. Reports must be submitted to the Division no later than forty five (45) calendar days after the end of the calendar quarter.

DISENROLLMENT**
Provide the total number of disenrollments categorized as Involuntary as defined by the Contract Sections 4.7 and 4.8. The report will be due to the NC DMA no later than forty five (45) calendar days after the end of the calendar quarter.

HEALTH PLAN DESCRIPTIVE INFORMATION:
HEDIS MEASURES

TOTAL ENROLLMENT BY PERCENTAGE**
Provides an overview of the mix of the Plan membership. MCOs report the percentage of total member months contributed by each product line, age and sex during the measurement year.

ENROLLMENT BY PRODUCT LINE
Reports the total number of members enrolled for each product line stratified by age and sex. Medicaid is reported in the member months contributed by enrollees during the measurement year, it is stratified by Medicaid eligibility category, age and sex.

**** The reported rate for this measure must also include a subset rate for Children with Special Healthcare Needs as defined by the aid categories outlined in the HCFA Document "Review Criteria for Certain Children with Special Needs"**

****

The Plan shall within ten (10) days of filing the National Association of Insurance Commission (NAIC) Annual Statement, HMO Edition, with the North Carolina Department of Insurance, file a copy of said statement with the Division. The Plan shall within ten (10) days of filing the NAIC Quarterly Statement with the North Carolina Department of Insurance, file a copy of said document with the Division of Medical Assistance. Within sixty (60) days of the end of each calendar year quarter, financial data shall be reported on total revenue, expenses, overall loss ratio, medical loss ratio, gross margin, administrative loss ratio, operating profit after corporate expenses for most recent completed quarter and forecasted quarters (modified HEDIS). The Plan shall file within sixty (60) days of the end of each calendar quarter reports including, but not limited to: Balance Sheet, Statement of Revenue, Expenses and Net Worth, Cash Flow Statement, Enrollment and Utilization Table, Number of High Cost Patients, and Incurred but not Reported Statement Expenses. These forms may be obtained from the Division of Medical Assistance.

APPENDIX VI

COMMUNITY RESOURCES

School Health Services: School-based health services can be an effective means of making primary and preventive health care available to children, and in particular to adolescents, who may not otherwise receive these services. Health plans are encouraged to enter into agreements or subcontracts for the provision of services at school-based health centers. Plans must establish written policies and procedures for the coordination of services delivered at school-based sites.

Maternity Care Coordination (MCC): In 1987, the Baby Love Program was introduced to improve access to health care and support services for low-income pregnant women and young children. Key features of the Baby Love Program include:

* Expansion of Medicaid eligibility to one hundred eighty five percent (185%) of the Federal Poverty Level (FPL) for pregnant women and infants;
* Outreach and program promotion to increase participation rates in Medicaid;
* Implementation of presumptive eligibility and other measures to reduce red tape in the application process;
* Implementation of a statewide Maternity Care Coordination system to enhance local recipient advocacy, eliminating barriers to utilization of services.

The care coordination system is designed to:

* Ensure that eligible women receive all health care services necessary for positive pregnancy outcomes;
* Facilitate integrated service delivery among the various health and social service providers;
* Monitor the effectiveness of care coordination services in meeting the Recipient's medical, nutritional, psychosocial, and resource needs.

MCCs are located in all one hundred (100) county health departments, most rural and community health centers, and the Cherokee Health Delivery System. MCCs work in concert with the recipient's medical provider to assist women in the Medicaid eligibility process, to arrange transportation to medical appointments, to make referrals to appropriate community agencies, and to provide follow-up in any of these areas as needed.

Child Service Coordination: The Child Service Coordination Program was introduced in October of 1990 to enhance services to children and their families. Since its inception, the CSC Program has worked to improve and enhance health care to children during their first years of life. CSC involves teams of parents, professionals and agencies working collaboratively to enhance the health care delivery system. The CSCs are based in the local health departments.

Women, Infants, and Children (WIC) Program: Congress created this Special Supplemental Food Program in 1972 to meet the special nutritional needs of pregnant, breastfeeding and postpartum women, infants and children up to age five (5). Currently, WIC operates through State health departments. The supplemental foods provided by WIC contain nutrients often lacking in diets of the target population. The WIC program provides information and education

emphasizing the relationship between nutrition and good health. In addition, WIC offices make referrals to health and social services to help clients access Health Check Screenings, drug and alcohol use counseling, family planning, Food Stamps, migrant services, Head Start, Even Start, and child abuse counseling.

Developmental Evaluation Centers: The Developmental Evaluation Center's (DEC) Program consists of a statewide network of 18 regional centers with a team of professionals with specialties in pediatrics, social work, psychology, speech and language, hearing, physical/occupational therapy, special education, nursing, and nutrition. Service priorities are directed to young children having or suspected of having multifaceted, severe conditions and lacking access to other care providers. These children may have physical, psychological, neuromotor, socio-emotional, speech, language, hearing, or learning problems. The services offered are:

* individual assessment/evaluation and diagnosis;
* treatment and client instruction;
* service coordination;
* screening; and
* technical assistance to other providers.

DECs uses a holistic approach with services tailored to meet the unique needs of each client and family. Through a State interagency agreement, DECs are the coordinative agency under IDEA (Public Law 99-457) for evaluation of children under five (5) years of age. DECs also serve as coordinator/host of regional genetics clinics, as a resource for accessing assistive technology, as a crucial support service to local education agencies (LEAs), as a staff-training source for other agencies and as a field placement site for students/future professionals. Preference is given to children under age five, but some older children are served. Anyone may refer a client with the family's consent. Families are not billed for evaluations of children under age five, but may be billed for treatments of children under age three. If billed, a family's income is compared to federal poverty guidelines and charges are based on a sliding scale. Medicaid is billed if the client is eligible, and insurance is billed with the family's consent.

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP - MR/DD): CAP - MR/DD provides an alternative to care in an ICF/MR. The program is available statewide to individuals of all ages. Each CAP-MR/DD client has a case manager designated by the Area Program. This case manager arranges, coordinates and monitors CAP-MR/DD services as well as other aspects of the client's care in the community.

HIV Case Management Services (HIV CMS): HIV CMS assist Medicaid-eligible Recipients who have a diagnosis of HIV seropositivity to access needed medical, social, educational and other services. Case managers evaluate a recipient's situation; develop and implement an individualized plan of care to meet the recipient's service needs; assist in locating and contacting providers, programs and local resources; coordinate the delivery of services when multiple providers or programs are involved; and monitor to ensure that the services received meet the Recipient's needs and are consistent with quality care.

APPENDIX VI – COMMUNITY RESOURCES
PAGE 3

Community Alternatives Program (CAP): CAP provides an alternative to nursing facility and hospital care for children and adults who have complex medical needs. This is a statewide program with certain enrollment limits. Centers for Medicare and Medicaid Services (CMS) allows the State to serve a specific number of individuals each year. The Division allots a portion of the State's limit to each CAP county. Each county program is administered by a lead agency selected by the county commissioners.

Nursing Facility Care (Skilled and Intermediate Care Nursing): A nursing facility is licensed and certified by Division of Facility Services to provide both skilled and intermediate nursing care. All Medicaid certified beds are interchangeable as skilled or intermediate beds based on the level of care needed by the patient.

Other Community Resources include:

1. Planned Parenthood;
2. Local Transportation Options;
3. Local Health Department.

APPENDIX VII

LONG TERM CARE SERVICES (USE OF AN FL-2)

The Long-Term Care Services form (FL-2) should be completed by the attending physician with the assistance of the county department of social services, in conjunction with the facility or responsible party when it is known that the patient is to be referred to a nursing facility or CAP. All copies of the form must be submitted when requesting prior approval. Assure that the form contains sufficient data for patient identification and medical condition to allow the medical review consultants to render an appropriate decision as to the level of care required by the patient. All FL-2s requesting prior approval (except request for retroactive approval) should be sent through the county department of social services.

The following chart describes when to submit a FL-2 for prior approval:

	To Hospital	To ICF (Facility)	To SNF (Facility)	To ICF (CAP)	To SNF (CAP)
From Home	No FL-2	Approved FL-2	Approved FL-2	Approved FL-2	Approved FL-2 (SNF)
From Hospital	No FL-2	Approved FL-2	Approved FL-2	Approved FL-2	Approved FL-2 (SNF)

APPENDIX VIII

DIVISION GUIDELINES FOR FOCUSED CARE STUDIES

Focused qualities of care studies are detailed investigations of certain aspects of healthcare services which are designed to answer defined questions about the quality and appropriateness of care and offer direction in improving that care. Through focused quality of care studies, the organization can reasonably expect to improve care and service.

A focused study may be conducted by reviewing medical records, claims, or other administrative data, or by conducting special surveys. All well designed studies have the following components:

1. A clearly defined study question which focuses on relevant areas of concern specific to Members in the organization. A study question may be narrowly focused or broad and more complex. The study area selected should reflect the organization's Medicaid enrollment in terms of demographic characteristics and the prevalence of risk and/or disease;
2. Well-defined clinical or quality indicators help answer the study question. Indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area. Quality indicators are objective, measurable, and based on current knowledge and clinical experience. Practice guidelines or health service standards should be used in the development of indicators;
3. A standard or standards against which the organization compares itself;
4. Methods to collect sufficient data in a timely and appropriate manner to detect problem areas;
5. A method for analyzing the results; and
6. A system to develop, implement, and evaluate improvement strategies.

Possible Clinical Areas of Concern:

childhood immunizations
prenatal care
pregnancy prevention
sexually transmitted diseases
smoking prevention and cessation
cervical cancer screening
lead toxicity
health checks
cardiovascular disease
asthma
diabetes
hypertension
ETOH and other substance abuse
cholesterol screening/management
prescription drug abuse
adult health screenings
breast cancer/mammography screening

Possible Health Services Delivery Areas of Concern:

access to care
coordination of services
telephone medical advice
use of emergency services
health education
continuity of care
utilization of services

Resources for developing Focused Care Studies:

1) Health Care Quality Improvement Studies in Managed Care Settings: A Guide for State Medicaid Agencies, National Committee for Quality Assurance, 1994.
2) A Healthcare Quality Improvement System for Medicaid Managed Care: A Guide for States, Medicaid Bureau, HCFA, 1993.

APPENDIX IX

GRIEVANCE PROCEDURES

The Plan shall have a timely and organized internal grievance system with written policies and procedures. The Plan shall establish a grievance system for their member that meets all regulatory requirements, including a grievance process, an appeal process and access to the State's fair hearing system.

The grievance process is the procedure of addressing member grievances. A grievance is a member's expression of dissatisfaction with any aspect of their care other than the appeal of actions, (which is an appeal). The member may file a grievance either orally or in writing.

A. General Requirements of Grievance System

The Plan must:

1. give members any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll free numbers with TTY/TDD and interpreter capability;
2. acknowledge receipt of each grievance and appeal; and
3. ensure that decision makers on grievance and appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the member's condition or disease if any of the following apply:
    i. a denial appeal is based on lack of medical necessity;
    ii. a grievance regarding denial of expedited resolutions or an appeal or
    iii. any grievance or appeal involving clinical issues.

Pursuant to 42 C.F.R. 438.414, the Plan must provide information on grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract. The Plan shall provide to enrollees the following:

1. the member's right to a state fair hearing, how to obtain a hearing and representation rules at a hearing;
2. the member's right to file grievances and appeals and their requirements and timeframes for filing;
3. the availability of assistance in filing;
4. the toll free numbers to file oral grievances and appeals;
5. the member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the Plan's action is upheld in a hearing, the member may be liable for the cost of any continued benefits; and
6. any State determined provider appeal rights to challenge the failure to the organization to cover a service.

B. Recordkeeping and Reporting

The Plan must maintain records of grievances and appeals as follows.

1. The Plan will maintain records that include a copy of the original grievance, the response, and the resolution. This system shall distinguish Medicaid recipients from other Plan Members and identify the grievant and the date of complaint;
2. Provide for retention of the records described~~,~~ above, for five (5) years following a final decision or close of the grievance. If any litigation, claims negotiation, audit, or other action involving the records has been started before the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular five-year period, whichever is later**.**

C. Service Authorizations and Notices of Action

Action is defined in Appendix I, 1.1 and below, as the:

1. denial or limited authorization of a requested service (including the type or level of service);
2. reduction, suspension, or termination of a previously authorized service;
3. denial, in whole or in part, payment for a service;
4. failure to provide services in a timely manner. The Plan must ensure that appropriate services are available as stated in Section 6.5, Appointment Availability of this contact; or
5. failure of the Plan to act within the timeframes.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

The Plan must notify the requesting provider and enrollee of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice of adverse action to the provider need not be in writing, the enrollee notice must be in writing.

The Notice of Adverse Action must explain:

1. the action the Plan has taken or intends to take;
2. the reasons for the action;
3. the member's or provider's right to file an appeal;
4. how to contact the consumer relations or member services office and how to file an appeal with the Plan;
5. the circumstances under which an expedited resolution is available and how to request it;
6. for members, the right to file an informal or formal appeal with the State pursuant to 10 NCAC 26I and how to obtain more information about those procedures; the circumstances under which health services must be continued;

6a. For provider and subcontractors, the right to file an appeal with the State pursuant to 10 NCAC 26K;

7. that filing or resolving a grievance through the Plan's internal grievance system is not a prerequisite to filing an informal or formal appeal with the State pursuant to 10 NCAC 26I;
8. how to request that benefits be continued and the circumstances under which the enrollee may be required to pay the costs of these services; pending resolution of the grievance, appeal or state fair hearing;
9. how to request that benefits be continued and the circumstances under which the enrollee may be required to pay the costs of these services, pending resolution of the grievance, appeal or state fair hearing;
10. the right of the member in an informal appeal to represent himself or use legal counsel, a relative, a friend or other spokesman, and of the potential availability of free legal services;
11. the right to enroll in another Plan if the Member is not satisfied at the end of the grievance process or State appeal process;
12. that Member has a right to a second opinion if medically necessary, at the Plan's expense and how to exercise that right;
13. the specific regulations that support, or the change in Federal or State law that requires, the notice of fair hearing.

The Plan must make the information and notices described in this Appendix readily available orally and in writing in the recipient's primary language and in each prevalent non-English language in its service area. Written material must use easily understood language and format, be available in alternative formats and in an appropriate manner that takes into consideration those with special needs.

All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats. The Plan must make these services available free of charge.

D. Timeframes for Notice of Action

1. Termination, Suspension or Reduction of Services
   The Plan gives notice at least ten (10) days before the date of action when the action is a termination, suspension or reduction of previously authorized Medicaid covered services, except:

   a. The period of advanced notice is shortened to five (5) days if probable recipient fraud has been verified;
   b. By the date of the action for the following:
      1. in the death of a recipient;
      2. a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he/she understands that this must be the result of supplying that information);
      3. the recipient's admission to an institution where he/she is ineligible for further services;
      4. the recipient's address is unknown and mail directed to him/her has no forwarding address;
      5. the recipient has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth;
      6. the recipient's physician prescribes the change in the level of medical care;
      7. an adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989; or;
      8. the safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate or transfer is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for thirty (30) days (applies only to adverse actions for NF transfers.

2. Denial of Payment
   The Plan gives notice on the date of action when the action is a denial of payment.

3. Standard Service Authorization Denial
   When the notice of action is a standard service authorization denial, the Plan gives notice as expeditiously as the enrollee's health condition requires and within the Division established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if the member, or the provider, requests extension; or the Plan justifies a need for additional information and how the extension is in the member's interest (upon State request).

   If the Plan extends the timeframe, it must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

4. Expedited Service Authorization denial
   For cases in which a provider indicates, or the Plan determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Plan gives notice must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.

   Extension -The Plan may extend the three (3) working days time period by up to fourteen (14) calendar days if the member requests an extension, or if the Plan justifies a need for additional information and how the extension is in the enrollee's interest (upon State request).

5. Untimely Service Authorization Decisions
   The Plan gives notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

D. Appeal Process

1. Appeal
   The Plan must define appeal as the request for review of an "action", as defined in Appendix I, 1.3.

   The member may file a Plan level appeal. A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal.

2. Appeal process: Timing
   The enrollee or provider may file an appeal within a reasonable timeframe that cannot be less than twenty (20) days and not to exceed ninety (90) days from the date on the notice of action.

3. Appeal Process: Procedures
   The enrollee or provider may file an appeal either orally or in writing and must follow an oral filing with a written, signed appeal.

   The Plan must:

   a. ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the enrollee or the provider requests expedited resolution;
   b. provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;
   c. allow the enrollee and representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records;
   d. consider the enrollee, representative, or estate representative of a deceased enrollee as parties to the appeal.

4. Appeal process: Resolution and Notification
   The Plan must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within State established timeframes not to exceed forty five (45) days from the day the Plan receives the appeal

5. Extension
   The Plan may extend the timeframes by up to fourteen (14) calendar days if the member requests the extension; or the Plan shows that there is need for additional information and how the delay is in the enrollee's interest (upon State request).

6. Requirements following extension
   For any extension not requested by the enrollee, the Plan must give the member written notice of the reason for the delay.

7. Appeal Process: Format and content of resolution notice
   The Plan must provide written notice of disposition. The written resolution notice must include:

   a The results and date of the appeal resolution.
   b. For decisions not wholly in the member's favor:
      1. The right to request a State fair hearing,
      2. How to request a State fair hearing,
      3. The right to continue to receive benefits pending a hearing,
      4. How to request the continuation of benefits, and
      5. If the Plan's action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits.

8. Appeal and State Fair Hearing Process: Continuation of benefits
   The MCO or PIHP must continue the enrollee's benefits if:

   a. The appeal is filed timely, meaning on or before the later of the following:
      1. Within ten (10) days of the Plan mailing the notice of action;
      2. The intended effective date of the Plan's proposed action.
   b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
   c. The services were ordered by an authorized provider;
   d. The authorization period has not expired; and
   e. The member requests extension of benefits.

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9. Appeal and State Fair Hearing process: Duration of continued or reinstated benefits
   If the Plan continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

   a. The member withdraws the appeal;
   b. The member does not request a fair hearing within ten (10) days from when he MCO mails an adverse Plan decision;
   c. A State fair hearing decision adverse to the member is made;
   d. The authorization expires or authorization service limits are met.

10. Appeal and State fair hearing process: Enrollee responsibility for services furnished while the appeal is pending.
    The Plan may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the Plan's action.

11. Appeal and State fair hearing process: Effectuation when services were not furnished
The Plan must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires if the services were not furnished while the appeal is pending and the Plan, or the State fair hearing officer reverses a decision to deny, limit, or delay services.

12. Appeal and State fair hearing process: Effectuation when services were furnished
The Plan or the State must pay for disputed services, in accordance with State policy and regulations, if the Plan, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending.

E. Expedited Appeals Process – General.

The Plan must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

Expedited appeals are just a "special type" of appeals. The Plan is required to follow all standard regulation appeal regulations for expedited requests except where differences are specifically noted in the regulation for expedited resolution.

1. Expedited Appeals Process – Authority to File.
The member or provider may file an expedited appeal either orally or writing. No additional member follow-up is required.

2. Expedited Appeals Process – Procedures
The contractor must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

3. Expedited Appeal Process: Resolution and Notification
The Plan must resolve each expedited appeal and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to exceed three (3) working days after the Plan receives the appeal.

   Extension. – The Plan may extend the timeframes by up to fourteen (14) calendar days if the enrollee requests the extension; or the Plan shows that there is need for additional information and how the delay is in the enrollee's interest (upon State request).

   Requirements following extension- for any extension not requested by the enrollee, the Plan must give the member written notice of the reason for the delay.

4. Expedited Appeal Process: Format of resolution notice
In addition to written notice, the Plan must also make reasonable efforts to provide oral notice.

5. Expedited Appeal Process: Punitive action
The MCO or PIHP must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.

6. Expedited Appeal Process: Action following denial of a request for expedited resolution
   If the Plan denies a request for expedited resolution of an appeal, it must:

   a. Transfer the appeal to the standard timeframe of no longer than forty five (45) days from the day the Plan receives the appeal with a possible fourteen (14) day extension;
   b. Give the member prompt oral notice of the denial (make reasonable efforts) and a written notice within two (2) calendar days. The notice should include the information listed under Section C. Service Authorizations and Notices of Action, Notice of Adverse Action found on Page 2 of this Appendix;
   c. Follow the appropriate North Carolina Department of Insurance (DOI) expedited appeal process and procedures except to the extent those processes and procedures are preempted by Federal statues and regulations in which case the Plan shall comply with the appropriate Federal statues and regulations;
   d. Other information for enrollees and providers would include:

      1. An enrollee may request a State fair hearing;
      2. The provider may request a State fair hearing only if the State permits the provider to act as the enrollee's authorized representative;
      3. The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than twenty (20) or in excess of ninety (90) days from whichever of the following dates applies:

         a. If the State requires exhaustion of the Plan level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on the Plan's notice of action.
         b. The State must reach its decisions within the specified timeframes: Standard resolution: within ninety (90) days of the date the enrollee filed the appeal with the Plan if the enrollee filed initially with the Plan (excluding the days the enrollee took to subsequently file for a State fair hearing) or the date the enrollee filed for direct access to a State fair hearing.
         c. Expedited resolution (if the appeal was heard first through the Plan appeal process): within three (3) working days from agency receipt of a hearing request for a denial of a service that:

            1. Meets the criteria for an expedited appeal process but was not resolved expedited appeal timeframes, or were resolved wholly or partially adversely to the enrollee using the Plan’s expedited appeal timeframes.

APPENDIX X

ENCOUNTER DATA MINIMUM REQUIREMENTS

Element	Definition
PHYSICIAN AND OTHER PROVIDERS:	
Beneficiary ID	a number that uniquely identifies an individual eligible for benefits
Beneficiary Name	name of the beneficiary
Beneficiary Date of Birth	beneficiary date of birth
Beneficiary Gender	beneficiary gender
EPSDT Indicator	indicator that procedure was performed as part of an EPSDT program
Facility ID	unique number assigned to the facility where the service was provided
First Date of Service	first date procedure was rendered
Last Date of Service	last date procedure was rendered
Other Diagnosis Code (take maximum possible)	diagnosis code of any condition other than the principle condition
Physician/Provider ID	unique number assigned to each physician or other provider of service
Place of Service	code indicating type of facility in which a service was rendered by a provider
Plan ID	number assigned to the Plan with which the beneficiary is associated
Principle Diagnosis Code	diagnosis code for the principle condition
Procedure Code	(take code identifying the medical procedure maximum possible) performed (outpt); principle procedure related to the principle diagnosis (inpt)
Provider Location Code	code for the geographic or geopolitical subdivision in which the service is rendered
Record Format	code indicating record type, (e.g., physician, hospital)
Specialty Code	identification of medical specialty or classification of the provider

APPENDIX X – ENCOUNTER DATA
PAGE 2

Element	Definition
Unit of Service/Quantity	quantitative measure of service (e.g., days, visits, miles, injections)
HOSPITAL:	
Beneficiary ID	a number that uniquely identifies an individual eligible for benefits
Beneficiary Name	name of the beneficiary
Beneficiary Date of Birth	beneficiary date of birth
Beneficiary Gender	beneficiary gender
Attending/Referring Physician ID	unique number assigned to the attending or referring physician
Date of Service	date of the procedure/date a prescription was filled
Discharge Patient Destination	code indicating patient's destination upon discharge, or death
Facility ID	unique number assigned to the facility where the service was provided
From Date of Service	first date covered by this encounter period
Length of Stay	number of inpatient hospital days
Other Diagnosis Code (take maximum possible)	diagnosis code of any condition other than the principle condition
Performing Provider ID	unique number assigned to the provider performing the major procedure
Plan ID	number assigned to the Plan with which the beneficiary is associated
Principle Diagnosis Code	diagnosis code for the principle condition
Procedure Code (take maximum possible)	code identifying the medical procedure performed (outpt); principle procedure related to the principle diagnosis (inpt)
Provider Location Code	code for the geographic or geopolitical subdivision in which the service is rendered
Provider Type	code indicating the classification of the facility providing the service

APPENDIX X – ENCOUNTER DATA
PAGE 3

Element	Definition
Record Format	code indicating record type (e.g., physician, hospital)
Revenue Code	code which identifies a specific accommodation, ancillary service or billing center
HOSPITAL:	
Through Date of Service	inpatient release date/last treatment date
Type of Record	code indicating inpatient, outpatient, etc.
Unit of Service/Quantity	measure of service quantity (days, visits)
LONG TERM CARE:	
Beneficiary ID	unique individual identification number
Beneficiary Name	name of the beneficiary
Beneficiary Date of Birth	beneficiary date of birth
Beneficiary Gender	beneficiary gender
Date of Service	date of procedure/date prescription filled
Days Since Admission	number of days patient in LTC facility
Discharge Patient Destination	patient's destination upon discharge or death
Facility ID	unique facility identification number
From Date of Service	first date covered by this encounter period
National Drug Code	code assigned to all drugs by the FDA
Physician/Provider ID	unique number assigned to physician/provider
Plan ID	number assigned to the Plan with which the beneficiary is associated
Procedure Code (take maximum possible)	code identifying the medical procedure performed (outpt); principle procedure related to the principle diagnosis (inpt)
Provider Location Code	code for the geographic or geopolitical subdivision in which the service is rendered

APPENDIX X – ENCOUNTER DATA
PAGE 4

Element	**Definition**
Record Format	record type (e.g., physician, hospital)
Revenue Code	code identifying specific accommodation, ancillary service or billing center
Specialty Code	identification of medical specialty or classification of the provider
Through Date of Service	inpatient release date/date of last treatment
Unit of Service/Quantity	quantitative measure of service (e.g., days, visits, miles, injections)
DRUGS:	
Beneficiary ID	Unique individual beneficiary identification
Beneficiary Name	name of the beneficiary
Beneficiary Date of Birth	beneficiary date of birth
Beneficiary Gender	beneficiary gender
Date of Service	date of procedure/date prescription filled
National Drug Code	code assigned to all drugs by the FDA
Physician/Provider ID	unique number assigned to each physician or other provider of service
Plan ID	number assigned to the Plan with which the beneficiary is associated
Provider ID	unique number assigned to each pharmacy provider of service/dental provider
Provider Location Code	code for the geographic or geopolitical subdivision in which the service is rendered
Quantity	number of units of the drug dispensed (e.g., cc, capsule, tablet)
Record Format	code indicating record type (e.g., physician, hospital)
Unit of Measure	unit in which a drug is dispensed (e.g., cc, capsule, tablet)

APPENDIX X – ENCOUNTER DATA
PAGE 5

Element	**Definition**
Unit of Service/Quantity	quantitative measure of service (e.g., days, visits, miles, injections)
DENTAL:	
Beneficiary ID	a number that uniquely identifies an individual eligible for benefits
Beneficiary Name	name of the beneficiary
Beneficiary Date of Birth	beneficiary date of birth
Beneficiary Gender	beneficiary gender
DENTAL	
Date of Service	date of the procedure/date a prescription was filled
Dental Quadrant	code identifying the quadrant of the mouth in which service was rendered
EPSDT Indicator	indicator that procedure was performed as part of an EPSDT program
Physician/Provider ID	unique number assigned to each physician or other provider of service
Place of Service	code indicating type of facility in which a service was rendered by a provider
Plan ID	number assigned to the Plan with which the beneficiary is associated
Provider ID	unique number assigned to each pharmacy provider of service/dental provider
Provider Location Code	code for the geographic or geopolitical subdivision in which the service is rendered
Record Format	code indicating record type (e.g., physician, hospital)
Tooth Number	code identifying the specific tooth being treated
Unit of Service/Quantity	quantitative measure of service (e.g., days, visits, miles, injections)

APPENDIX XI
MEDICAID PM/PM RATES
CURRENT RATES

WFFA

< 1 Males and Females	$ 294.40
1 - 5 Males and Females	$ 51.15
6 - 13 Males and Females	$ 32.38
14 - 20 Females	$ 102.82
14 - 20 Males	$ 78.03
21 - 44 Females	$ 152.26
21 - 44 Males	$ 301.00
45 - 64 Males and Females	$ 373.76

MPW - SOBRA WOMEN	$ 223.76

MIC/OTHER CHILDREN

<1 Males and Females	$ 316.54
1 - 5 Males and Females	$ 51.15
6 - 13 Males and Females	$ 32.38
14 - 20 Females	$ 73.39
14 - 20 Males	$ 52.14

DELIVERY PAYMENT	$ 2,871.99

BLIND & DISABLED

< 1 Males and Females	$ 1,502.95
1 - 20 Males and Females	$ 160.99
21 - 44 Females	$ 310.15
21 - 44 Males	$ 389.21
45 - 64 Males and Females	$ 511.93

APPENDIX XII

BUSINESS TRANSACTIONS

All HMOs, which are not Federally qualified, must disclose to the Division information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.)

A. Definition of a Party in Interest - As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:

(1) Any director, officer, partner or employee responsible for management or administration of an HMO and HIO; any person who is directly or indirectly the beneficial owner of more than five (5) % of the equity of the HMO; any person who is the beneficial owner of more than five (5) % of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation laws;

(2) Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five (5)% of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five (5) % of the assets of the HMO;

(3) Any person directly or indirectly controlling, controlled by, or under common control with an HMO; or

(4) Any spouse, child, or parent of an individual described in subsections 1, 2, or 3.

B. Types of Transactions Which Must Be Disclosed - Business transactions which must be disclosed include:

(1) Any sale, exchanges or lease of any property between the HMO and a party interest;

(2) Any lending of money or other extension of credit between the HMO and a party interest; and

(3) Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information, which must be disclosed in the transactions, listed in subsection B between an HMO and a party in interest includes:

(1) The name of the party in interest for each transaction;
(2) A description of each transaction and the quantity or units involved;
(3) The accrued dollar value of each transaction during the fiscal year; and
(4) Justification of the reasonableness of each transaction.

APPENDIX XII – BUSINESS TRANSACTIONS
PAGE-2

If this HMO contract is being renewed or extended, the HMO must disclose information on these business transactions, which occurred during the prior contract period. If the contract is an initial contract with Medicaid, but the HMO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions, which must be reported, are not limited to transactions related to serving the Medicaid enrollment. All of these HMO business transactions must be reported.

APPENDIX XIII

PROVIDER MANUALS AND BULLETINS

Adult Care Homes Manual – Available on DMA web site*

Ambulance Services Manual – Available on DMA web site*

Abortions -- September 1998 Medicaid Special Bulletin

Chiropractic Services Manual

Community Care Manual - Available on DMA web site*

Developmental Evaluation Centers Handout

Durable Medical Equipment Manual - Available on DMA web site*

Encounter Data Submission Manual

April 2003 Medicaid Health Check Special Bulletin*

Hearing Aid Services Manual - 1993

Hospital Services Manual - Available on DMA web site*

Hysterectomy—1996 Medicaid Fair Handout

Physician Services Manual

Planned Parenthood - Special Bulletin November 1992

Podiatry - Information Sheet

Sterilization – Medicaid Bulletin Article, April 2000
Medicaid Bulletin Article, June 2000

Transportation – DMA Administrative Letter No 01-95, July 1, 1994
July 15, 1994
October 15, 1995

Optical Manual –Available on DMA web site*

DMA Web Site address to access online manuals: http://www.dhhs.state.nc.us/dma/

Doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

Whom should I talk to about an advance directive?

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

Where should I keep my advance directive?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

What if I have an advance directive from another state?

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

Where can I get more information?

Your health care provider can tell you how to get more information about advance directives by contacting:

This document was developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.

nc department of health and human services

Medical Care Decisions And Advance Directives
WHAT YOU SHOULD KNOW

What are My Rights?

Who decides about my medical care or treatment?

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

What is an "advance directive"?

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

Do I have to have an advance directive and what happens if I don't?

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

Living Will

What is a living will?

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

Health Care Power of Attorney

What is a health care power of attorney?

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

How should I choose a health care agent?

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

Advance Instruction for Mental Health Treatment

What is an advance instruction for mental health treatment?

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

Are there forms I can use to make an advance directive?

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

When does an advance directive go into effect?

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you.

What happens if I change my mind?

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your

APPENDIX XV

NC DMA MANAGED CARE
ACCESSIBILITY/AVAILABILITY STANDARDS FOR
MANAGED CARE ORGANIZATIONS

ACCESSIBILITY

A. Geographic Location
   1. The Provider Network for all covered in-plan services must be as geographically accessible to Medicaid enrollees as to non-Medicaid enrollees.

B. Distance/Travel Time
   1. Medicaid enrollees should have access to family practitioners, pediatricians, internists, consulting specialists, and ancillary providers within thirty (30) miles distance or forty five (45) minutes drive time.

C. Physician Ratio
   1. No more than two thousand (2000) members may be assigned to any one full-time equivalent provider in the Plan's network.

D. Facility Accessibility
   1. Contracted provider facilities must be accommodating for persons with physical disabilities. The health plan must observe for handicapped parking and entrance ramps; wheelchair accommodating door widths; and bathrooms equipped with handicapped railing.

E. New Member Orientation
   1. Member materials and information shall be sent to each new enrollee by the health plan within fourteen (14) days of effective date of enrollment.

F. Member Services
   1. Medicaid enrollees must have toll-free telephone access to a Member Services department to provide assistance, information, and education to members.

G. Support Services
   1. Transportation-
      Assistance with arrangement for transportation to medically necessary services through public and private means must be made available and communicated to Medicaid enrollees.

   2. Interpreters-
      Language interpretation services must be made available by telephone and/or in person enabling Medicaid enrollees to effectively communicate with the health plan and providers. TDD (telecommunication devices for the deaf) must also be made available for persons who have impaired hearing or a communication disorder.

AVAILABILITY

A. Appointments
   1. New Member Health Assessments/Preventive Care

   - ♦ All new Medicaid enrollees should be contacted by the health plan within the first ninety (90) calendar days enrollment to select a Primary Care Physician and schedule an initial health assessment encounter.

- New enrollees suspected, appearing, or known to be pregnant should be scheduled for an initial health assessment encounter within fifteen (15) business days of enrollment;

- Female enrollees must be allowed direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist;

- The Member has a right to a second opinion from a qualified health care professional within or outside the network, at no cost to the enrollee;

- Children in DSS custody should be scheduled for an initial encounter within seven (7) days of enrollment or immediately when a child is under age two (2) or if the DSS staff determines the child has chronic and/or emergent needs.

2. Emergency care- immediately upon presentation or notification;
3. Urgent care- within twenty-four (24) hours;
4. Routine sick care- within three (3) days;
5. Well/Preventive care- within ninety (90) days;
6. Routine specialty care- within ninety (90) days.

B. Office Wait Times
1. Walk-in- within two (2) hours;
2. Scheduled appointment- within one (1) hour;
3. Life-threatening emergencies- must be managed immediately.

C. After Hours Advice/Care
1. Medicaid enrollees must have access to medical advice/care twenty four (24) hours a day, seven (7) days a week. The health plan must provide toll-free telephone medical advice through an on-site /contracted staff of licensed health care professionals or through the network providers.

2. Return Calls to Members- Telephone inquiries made by members after hours for medical advice/care must be responded to by a licensed health care professional within one (1) hour of receiving the call.

APPENDIX XVI

GUIDELINES FOR STABILIZATION EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN LABOR

SEC. 1867. [42 U.S.C. 1395dd] (a) MEDICAL SCREENING REQUIREMENT--In the case of a hospital that has a hospital emergency department, if any individual (whether eligible or not for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND LABOR--

(1) IN GENERAL--If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) REFUSAL TO CONSENT TO TREATMENT--A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment

(3) REFUSAL TO CONSENT TO TRANSFER--A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) RESTRICTING TRANSFERS UNTIL INDIVIDUAL STABILIZED--

(1)RULE**.--**If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless--

(A) (i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1861(r)(1)) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1)), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph 2)) to that facility. A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) APPROPRIATE TRANSFER--An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility--
(i) has available space and qualified personnel for the treatment of the individual, and
(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) ENFORCEMENT.--

(1) CIVIL MONETARY PENALTIES—

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than fifty thousand ($50,000) or not more than twenty-five thousand ($25,000) in the case of a hospital with less than one hundred (100) beds) for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section, is subject to a civil money penalty of not more than fifty thousand ($ 50,000) for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in the title and State health care programs. The provisions of section 1128A (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a).

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I)) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) CIVIL ENFORCEMENT--

(A) PERSONAL HARM--Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) FINANCIAL LOSS TO OTHER MEDICAL FACILITY--Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) LIMITATIONS ON ACTIONS--No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) CONSULTATION WITH PEER REVIEW ORGANIZATIONS--In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least sixty (60) days for such review.

(e) DEFINITIONS--In this section:

(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) serious impairment to bodily functions, or
(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women who is having contractions--

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1866.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in outside a hospital's facilities at the direction of any person employed by (or paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual whom:

(A) has been declared dead; or

(B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1861(mm)(1)).

(f) PREEMPTION--The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) NONDISCRIMINATION--A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units), or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) NO DELAY IN EXAMINATION OR TREATMENT--A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) WHISTLEBLOWER PROTECTIONS--A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

APPENDIX XVII

REQUIREMENTS FOR PERFORMACE IMPROVEMENT PROJECTS

1. The Plan shall develop and implement performance improvement projects as defined in Section 7.1 of the contract. The project topics will be determined jointly by the Plan and the Division from the following clinical and non-clinical focus areas:
    - Primary, secondary and/or tertiary prevention of acute conditions;
    - Primary, secondary and/or tertiary prevention of chronic conditions;
    - Care of acute conditions;
    - Care of chronic conditions;
    - High-volume services;
    - High-risk services;
    - Continuity and coordination of care;
    - Availability, accessibility, and cultural competency of services;
    - Quality of provider/patient encounters;
    - Appeals, grievances, and other complaints;
2. Topics are identified through continuous data collection and analysis by the Plan of comprehensive aspects of patient care and member services;
3. Topics are systematically selected and prioritized to achieve the greatest practical benefit for enrollees.
4. The Quality Assurance/Performance Improvement program provides opportunities for enrollees to participate in the selection of project topics and the formulation of project goals;
5. Assessment of the Plan's performance for each selected topic is measured using one or more quality indicators. Quality indicators are objective, clearly and unambiguously defined and base on current clinical knowledge or health services research. Each project must represent the entire Medicaid enrollee population to which the specified measurement is relevant;
6. All indicators measure changes in health status, functional status, enrollee satisfaction or valid proxies of these outcomes;
7. The Plan selects some indicators for which data are available that allow comparison of the Plan's performance to that of similar Plans or to local, state, or national benchmarks;
8. The Plan establishes a baseline measure of its performance on each indicator, measures changes in performance, and continues measurement for at least one year after a desired level of performance is achieved. Each project must have ongoing measurement and intervention and demonstrable and sustained improvement in significant aspects of clinical care and nonclinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction;
9. A project demonstrates significant improvement by achieving a benchmark level of performance defined in advance by CMS or the Division. Benchmarks will be based on currently accepted standards, past performance data, or available national data;
10. When sampling is used, sampling methodology for performance assessment shall be such as to ensure that the data collected validly reflect the performance of all practitioners and providers who serve Medicaid enrollees and whose activities are subject of the indicator; and the care given to the entire population (including special populations with special and complex health care needs) to which the indicator is relevant;
11. When a project measures performance on quality indicators by collecting data on a subset (sample) of the units of analysis in the population to be studied, significant improvement is demonstrated by achieving defined benchmarks using a sample that is sufficiently large to detect the targeted amount of improvement;
12. The sample or subset of the study population shall be obtained through random sampling;
13. The samples used for the baselines and repeat measurements of the indicators shall be chosen using the same sampling frame and methodology;
14. The demonstrated improvement is reasonably attributable to interventions undertaken by the Plan (i.e., a project and its results have face validity);

APPENDIX XVII -REQUIREMENTS FOR PERFORMACE IMPROVEMENT PROJECTS PAGE 2

15. The Plan sustains the performance improvements for at least one year after the performance improvement is first achieved. Sustained improvement is documented through the continued measurement of quality indicators for at least one-year after the performance improvement project is completed;
16. The Plan is expected to use measures to analyze the delivery of services or quality of care, over and under utilization of services, disease management strategies, and outcomes of care. The Plan is expected to collect and use data from multiple sources such as medical record reviews, focused care studies, encounter data, HEDIS, claims processing, grievances, utilization review and member satisfaction surveys. The Division may specify the standard measures in uniform data collection and reporting instruments.

APPENDIX XVIII

PERFORMANCE BENCHMARKS

The plan shall meet or exceed the benchmarks listed below each contract year as evidenced by the required statistical reporting requirements on self-reported data. The Plan must meet the benchmarks listed below beginning the second year of the contract. Failure to meet or exceed the benchmarks may result in sanction or the Division may decline to renew the contract with the Plan. Benchmarks may be changed or added each contract year at the discretion of the Division.

Measure	Data Source	Benchmark
Childhood Immunizations(1)	HEDIS	56.02%
Childhood Immunizations (2)	HEDIS	46.71 %
Breast Cancer Screening	HEDIS	54.59%
Cervical Cancer Screening	HEDIS	58.39 %
Adolescent Immunizations (1)	HEDIS	27.71 %
Adolescent Immunizations (2)	HEDIS	13.03 %
Prenatal Care In the 1st Trimester	HEDIS	70.92%
Health Check Screenings	DMA	80%
Diabetic HbA1c Testing	HEDIS	68.21%